

Department of Social Services
Division of Medical Services

Fiscal Year 2008 Budget Request

Deborah Scott, Director

Printed with Governor's Recommendations

Page No.	Dept Rank	Decision Item Name	Department Amended Request					Governor's Recommendation				
			FTE	GR	FF	OF	Total	FTE	GR	FF	OF	Total
		Medical Services										
		Administration										
104	1	Core	263.71	3,844,986	8,606,047	2,025,836	14,476,869	263.11	3,831,193	8,604,847	2,025,836	14,461,876
	2	General Structure Adjustment						0.00	109,837	143,116	42,311	295,264
116	33	Mgd Care Expansion Actuarial Study	0.00	207,500	207,500	0	415,000	0.00	207,500	207,500	0	415,000
122	36	FADS Expansion	0.00	250,000	250,000	0	500,000	0.00	250,000	250,000	0	500,000
128	40	Investigation Expenses	0.00	500,000	500,000	0	1,000,000	0.00	0	0	0	0
		<i>Total</i>	263.71	4,802,486	9,563,547	2,025,836	16,391,869	263.11	4,398,530	9,205,463	2,068,147	15,672,140
		Healthcare Technology										
137	1	Core	0.00	0	4,600,000	4,950,000	9,550,000	0.00	0	4,600,000	4,950,000	9,550,000
146	22	Electronic Medical Histories	0.00	0	0	6,800,000	6,800,000	0.00	0	0	2,500,000	2,500,000
		<i>Total</i>	0.00	0	4,600,000	11,750,000	16,350,000	0.00	0	4,600,000	7,450,000	12,050,000
		Pharmacy Program Management										
155	1	Core	0.00	2,301,123	3,602,788	5,085,805	10,989,716	0.00	2,301,123	3,602,788	5,085,805	10,989,716
164	43	Pharmacy/Clinical Model	0.00	850,000	850,000	0	1,700,000	0.00	0	0	0	0
		<i>Total</i>	0.00	3,151,123	4,452,788	5,085,805	12,689,716	0.00	2,301,123	3,602,788	5,085,805	10,989,716
		Women & Minority Health Care Outreach										
173	1	Core	0.00	546,125	568,625	0	1,114,750	0.00	546,125	568,625	0	1,114,750
		<i>Total</i>	0.00	546,125	568,625	0	1,114,750	0.00	546,125	568,625	0	1,114,750
		Revenue Maximization Unit										
180	1	Core	4.00	0	94,850	94,850	189,700	4.00	0	94,850	94,850	189,700
	2	General Structure Adjustment						0.00	0	2,603	2,603	5,206
		<i>Total</i>	4.00	0	94,850	94,850	189,700	4.00	0	97,453	97,453	194,906
		TPL Contracts										
187	1	Core	0.00	0	3,000,000	3,000,000	6,000,000	0.00	0	3,000,000	3,000,000	6,000,000
		<i>Total</i>	0.00	0	3,000,000	3,000,000	6,000,000	0.00	0	3,000,000	3,000,000	6,000,000
		Information Systems										
197	1	Core	0.00	5,697,417	19,851,039	0	25,548,456	0.00	5,697,417	19,851,039	0	25,548,456
205	34	MMIS Modernization	0.00	0	34,940,000	5,660,000	40,600,000	0.00	0	34,940,000	5,660,000	40,600,000
		<i>Total</i>	0.00	5,697,417	54,791,039	5,660,000	66,148,456	0.00	5,697,417	54,791,039	5,660,000	66,148,456
		MC+ Enrollment										
212	1	Core	0.00	0	1,910,113	0	1,910,113	0.00	0	1,910,113	0	1,910,113
		<i>Total</i>	0.00	0	1,910,113	0	1,910,113	0.00	0	1,910,113	0	1,910,113
		Health Care Home Enrollment										
	1	Core						0.00	0	0	0	0
219	999	Health Care Home Enrollment Broker						0.00	2,500,000	2,500,000	0	5,000,000
		<i>Total</i>						0.00	2,500,000	2,500,000	0	5,000,000

Page No.	Dept Rank	Decision Item Name	Department Amended Request					Governor's Recommendation				
			FTE	GR	FF	OF	Total	FTE	GR	FF	OF	Total
		Pharmacy										
228	1	Core	0.00	135,282,533	409,334,365	71,832,897	616,449,795	0.00	135,282,533	409,334,365	71,832,897	616,449,795
240	7	Replace Life Science Trust Fund	0.00	38,500,000	0	0	38,500,000	0.00	38,500,000	0	0	38,500,000
1	13	Caseload Growth	0.00	835,982	1,376,781	0	2,212,763	0.00	0	0	0	0
17	14	Pharmacy PMPM Increase	0.00	37,770,869	62,204,961	0	99,975,830	0.00	28,345,827	46,682,832	0	75,028,659
36	23	FMAP	0.00	925,120	0	0	925,120	0.00	925,120	0	0	925,120
96	999	Provider Tax GR Replacement	0.00	5,000	0	0	5,000	0.00	5,000	0	0	5,000
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	79,319	130,631	0	209,950
63	999	Medical for Employed Disabled						0.00	2,950,114	4,858,553	0	7,808,667
		<i>Total</i>	0.00	213,319,504	472,916,107	71,832,897	758,068,508	0.00	206,087,913	461,006,381	71,832,897	738,927,191
		Pharmacy - Medicare Part D Clawback										
247	1	Core	0.00	184,800,000	1	0	184,800,001	0.00	184,800,000	1	0	184,800,001
255	17	Clawback Rate Increase	0.00	11,469,134	0	0	11,469,134	0.00	11,469,134	0	0	11,469,134
		<i>Total</i>	0.00	196,269,134	1	0	196,269,135	0.00	196,269,134	1	0	196,269,135
		Missouri RX Plan										
259	1	Core	0.00	0	0	19,602,166	19,602,166	0.00	0	0	19,602,166	19,602,166
265	999	Missouri Rx Commission						0.00	350,000	0	0	350,000
		<i>Total</i>	0.00	0	0	19,602,166	19,602,166	0.00	350,000	0	19,602,166	19,952,166
		Physician										
273	1	Core	0.00	147,107,865	264,660,260	4,194,685	415,962,810	0.00	147,107,865	264,660,260	4,194,685	415,962,810
1	13	Caseload Growth	0.00	614,179	1,011,492	0	1,625,671	0.00	0	0	0	0
36	23	FMAP	0.00	0	3,868,810	0	3,868,810	0.00	0	3,868,810	0	3,868,810
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	287,491	473,470	0	760,961
63	999	Medical for Employed Disabled						0.00	583,030	960,193	0	1,543,223
75	999	Health Risk Appraisals							11,067,515	18,227,125	0	29,294,640
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	11,443,972	18,847,112	0	30,291,084
287	0	Pay for Performance							1,100,000	1,811,593	0	2,911,593
		<i>Total</i>	0.00	147,722,044	269,540,562	4,194,685	421,457,291	0.00	171,589,873	308,848,563	4,194,685	484,633,121
		Dental										
296	1	Core	0.00	2,515,506	5,662,886	919,935	9,098,327	0.00	2,515,506	5,662,886	919,935	9,098,327
1	13	Caseload Growth	0.00	26,374	43,436	0	69,810	0.00	0	0	0	0
36	23	FMAP	0.00	0	68,521	0	68,521	0.00	0	68,521	0	68,521
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	1,642	2,703	0	4,345
63	999	Medical for Employed Disabled						0.00	61,865	101,885	0	163,750
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	312,451	515,987	0	828,438
		<i>Total</i>	0.00	2,541,880	5,774,843	919,935	9,236,658	0.00	2,891,464	6,351,982	919,935	10,163,381
		Premium Payments										
305	1	Core	0.00	54,461,244	90,726,492	0	145,187,736	0.00	54,461,244	90,726,492	0	145,187,736
1	13	Caseload Growth	0.00	81,920	134,914	0	216,834	0.00	0	0	0	0
314	21	Medicare Premium Increase	0.00	2,805,391	4,621,170	0	7,426,561	0.00	2,805,391	4,621,170	0	7,426,561
36	23	FMAP	0.00	0	941,941	0	941,941	0.00	0	941,941	0	941,941
		<i>Total</i>	0.00	57,348,555	96,424,517	0	153,773,072	0.00	57,266,635	96,289,603	0	153,556,238

Page No.	Dept Rank	Decision Item Name	Department Amended Request					Governor's Recommendation				
			FTE	GR	FF	OF	Total	FTE	GR	FF	OF	Total
Nursing Facilities												
323	1	Core	0.00	123,649,950	303,402,792	61,127,432	488,180,174	0.00	123,649,950	303,402,792	61,127,432	488,180,174
36	23	FMAP	0.00	0	2,589,714	0	2,589,714	0.00	0	2,589,714	0	2,589,714
96	999	Provider Tax GR Replacement	0.00	4,231,833	0	0	4,231,833	0.00	4,231,833	0	0	4,231,833
63	999	Medical for Employed Disabled						0.00	5,155	8,491	0	13,646
332	0	Nursing Fac Per Diem Rate Incr						0.00	10,000,000	16,470,000	0	26,470,000
		Total	0.00	127,881,783	305,992,506	61,127,432	495,001,721	0.00	137,886,938	322,470,997	61,127,432	521,485,367
Home Health - PACE												
338	1	Core	0.00	4,349,017	7,360,331	159,305	11,868,653	0.00	4,349,017	7,360,331	159,305	11,868,653
1	13	Caseload Growth	0.00	4,295	7,073	0	11,368	0.00	0	0	0	0
36	23	FMAP	0.00	0	64,439	0	64,439	0.00	0	64,439	0	64,439
347	999	In-Home Rate Increase	0.00	0	0	0	0	0.00	39,699	65,381	0	105,080
		Total	0.00	4,353,312	7,431,843	159,305	11,944,460	0.00	4,388,716	7,490,151	159,305	12,038,172
Rehab & Specialty Services												
356	1	Core	0.00	49,276,046	85,689,452	1,026,626	135,992,124	0.00	49,276,046	85,689,452	1,026,626	135,992,124
1	13	Caseload Growth	0.00	79,441	130,834	0	210,275	0.00	0	0	0	0
367	19	Hospice Rate Increase	0.00	197,131	324,655	0	521,786	0.00	197,131	324,655	0	521,786
36	23	FMAP	0.00	0	133,153	0	133,153	0.00	0	133,153	0	133,153
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	2,752	4,531	0	7,283
63	999	Medical for Employed Disabled						0.00	321,979	530,267	0	852,246
		Total	0.00	49,552,618	86,278,094	1,026,626	136,857,338	0.00	49,797,908	86,682,058	1,026,626	137,506,592
NEMT												
374	1	Core	0.00	11,069,594	24,230,651	0	35,300,245	0.00	11,069,594	24,230,651	0	35,300,245
1	13	Caseload Growth	0.00	23,407	38,549	0	61,956	0.00	0	0	0	0
381	20	NEMT Rate Increase	0.00	729,090	2,010,397	0	2,739,487	0.00	729,090	2,010,397	0	2,739,487
36	23	FMAP	0.00	212,312	0	0	212,312	0.00	212,312	0	0	212,312
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	3,172	5,223	0	8,395
		Total	0.00	12,034,403	26,279,597	0	38,314,000	0.00	12,014,168	26,246,271	0	38,260,439
Managed Care												
388	1	Core	0.00	173,972,073	567,382,617	168,479,824	909,834,514	0.00	173,972,073	567,382,617	168,479,824	909,834,514
1	13	Caseload Growth	0.00	2,005,901	3,303,525	0	5,309,426	0.00	0	0	0	0
28	18	Managed Care Rate Increase	0.00	25,614,829	42,185,141	0	67,799,970	0.00	25,614,829	42,185,141	0	67,799,970
36	23	FMAP	0.00	57,165	0	0	57,165	0.00	57,165	0	0	57,165
96	999	Provider Tax GR Replacement	0.00	2,005,809	0	0	2,005,809	0.00	2,005,809	0	0	2,005,809
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	166,530	274,260	0	440,790
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	7,248,738	11,943,263	0	19,192,001
		Total	0.00	203,655,777	612,871,283	168,479,824	985,006,884	0.00	209,065,144	621,785,281	168,479,824	999,330,249
Hospital Care												
410	1	Core	0.00	31,473,741	424,796,905	214,757,257	671,027,903	0.00	31,473,741	424,796,905	214,757,257	671,027,903
1	13	Caseload Growth	0.00	1,453,713	2,394,124	0	3,847,837	0.00	0	0	0	0
36	23	FMAP	0.00	0	3,755,965	0	3,755,965	0.00	0	3,755,965	0	3,755,965
96	999	Provider Tax GR Replacement	0.00	14,374,938	0	0	14,374,938	0.00	14,374,938	0	0	14,374,938
52	999	Medical for Foster Children	0.00	0	0	0	0	0.00	91,217	150,226	0	241,443
63	999	Medical for Employed Disabled						0.00	1,148,250	1,891,056	0	3,039,306
		Total	0.00	47,302,392	430,946,994	214,757,257	693,006,643	0.00	47,088,146	430,594,152	214,757,257	692,439,555

Page No.	Dept Rank	Decision Item Name	Department Amended Request					Governor's Recommendation				
			FTE	GR	FF	OF	Total	FTE	GR	FF	OF	Total
Tier 1 Safety Net Hospitals												
422	1	Core	0.00	0	23,000,000	0	23,000,000	0.00	0	23,000,000	0	23,000,000
		Total	0.00	0	23,000,000	0	23,000,000	0.00	0	23,000,000	0	23,000,000
FQHC Distribution												
429	1	Core	0.00	9,000,000	0	0	9,000,000	0.00	9,000,000	0	0	9,000,000
435	999	FQHC Health Info Technology						0.00	0	0	5,000,000	5,000,000
		Total	0.00	9,000,000	0	0	9,000,000	0.00	9,000,000	0	5,000,000	14,000,000
Federal Reimbursement Allowance												
441	1	Core	0.00	0	0	385,000,000	385,000,000	0.00	0	0	385,000,000	385,000,000
450	51	Authority Adjustment	0.00	0	0	367,000,000	367,000,000	0.00	0	0	367,000,000	367,000,000
		Total	0.00	0	0	752,000,000	752,000,000	0.00	0	0	752,000,000	752,000,000
Health Care Access (1115 Waiver)												
467	1	Core	0.00	683,499	1,696,517	198,167	2,578,183	0.00	683,499	1,696,517	198,167	2,578,183
1	13	Caseload Growth	0.00	19,903	32,779	0	52,682	0.00	0	0	0	0
17	14	Pharmacy PMPM Increase	0.00	46,693	76,899	0	123,592	0.00	35,042	57,710	0	92,752
36	23	FMAP	0.00	0	15,945	0	15,945	0.00	0	15,945	0	15,945
75	999	Health Risk Appraisals							235,298	387,513	0	622,811
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	11,871	19,551	0	31,422
		Total	0.00	750,095	1,822,140	198,167	2,770,402	0.00	965,710	2,177,236	198,167	3,341,113
CHIP (1115 Waiver - Children)												
475	1	Core	0.00	22,436,895	102,954,275	20,592,804	145,983,974	0.00	22,436,895	102,954,275	20,592,804	145,983,974
17	14	Pharmacy PMPM Increase	0.00	457,662	1,272,629	0	1,730,291	0.00	343,461	955,067	0	1,298,528
28	18	Managed Care Rate Increase	0.00	1,310,988	3,645,487	0	4,956,475	0.00	1,310,988	3,645,487	0	4,956,475
36	23	FMAP	0.00	0	590,288	0	590,288	0.00	0	590,288	0	590,288
75	999	Health Risk Appraisals							674,295	1,875,023	0	2,549,318
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	564,655	1,570,146	0	2,134,801
482	999	CHIP Affordability	0.00	0	0	0	0	0.00	2,067,688	5,749,659	0	7,817,347
		Total	0.00	24,205,545	108,462,679	20,592,804	153,261,028	0.00	27,397,982	117,339,945	20,592,804	165,330,731
Insurance Premium Offset												
	1	Core						0.00	0	0	0	0
488	0	Insurance Premium Offset						0.00	10,000,000	16,470,000	0	26,470,000
		Total						0.00	10,000,000	16,470,000	0	26,470,000
Uncompensated Care												
495	1	Core	0.00	0	25,000,000	0	25,000,000	0.00	0	25,000,000	0	25,000,000
		Total	0.00	0	25,000,000	0	25,000,000	0.00	0	25,000,000	0	25,000,000
Nursing Facility FRA												
502	1	Core	0.00	0	0	213,840,231	213,840,231	0.00	0	0	213,840,231	213,840,231
		Total	0.00	0	0	213,840,231	213,840,231	0.00	0	0	213,840,231	213,840,231
DESE Services												
512	1	Core	0.00	69,954	33,299,954	0	33,369,908	0.00	69,954	33,299,954	0	33,369,908
		Total	0.00	69,954	33,299,954	0	33,369,908	0.00	69,954	33,299,954	0	33,369,908

Page No.	Dept Rank	Decision Item Name	Department Amended Request					Governor's Recommendation				
			FTE	GR	FF	OF	Total	FTE	GR	FF	OF	Total
State Medical												
519	1	Core	0.00	25,486,493	0	888,660	26,375,153	0.00	25,486,493	0	888,660	26,375,153
17	14	Pharmacy PMPM Increase	0.00	1,163,827	0	0	1,163,827	0.00	873,415	0	0	873,415
75	999	Health Risk Appraisals							158,231	0	0	158,231
83	999	Physician-Related Rate Increase	0.00	0	0	0	0	0.00	418,313	0	0	418,313
Total			0.00	26,650,320	0	888,660	27,538,980	0.00	26,936,452	0	888,660	27,825,112
Medicaid Supplemental Pool												
527	1	Core	0.00	0	24,107,486	11,590,599	35,698,085	0.00	0	24,107,486	11,590,599	35,698,085
Total			0.00	0	24,107,486	11,590,599	35,698,085	0.00	0	24,107,486	11,590,599	35,698,085
Total Medical Services Core			267.71	988,024,061	2,435,538,446	1,189,367,079	4,612,929,586	267.11	988,010,268	2,435,537,246	1,189,367,079	4,612,914,593
Total Medical Services			267.71	1,136,854,467	2,609,129,568	1,568,827,079	5,314,811,114	267.11	1,184,509,332	2,689,435,542	1,569,571,993	5,443,516,867

NEW DECISION ITEM

RANK: 13

Department: Social Services
Division: Medical Services
DI Name: Medicaid Caseload Growth

Budget Unit: 90541C, 90544C, 90546C, 90547C, 90564C, 90550C,
90561C, 90551C, 90552C
DI#: 1886033

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	5,145,115	8,473,507		13,618,622
TRF				
Total	5,145,115	8,473,507		13,618,622
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Growth within current eligibility guidelines	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: To provide for anticipated caseload increases in existing Medicaid programs.

This funding is requested to provide for anticipated caseload changes of existing Medicaid programs. This does not include any expansion due to changes in any eligibility guidelines. The Federal Authority is Social Security Act 1902(a)(10), 1903(w), 1905, 1915(d), 1915(b), 1923(a)-(f), 2100 and 1115 waiver; 42 CFR 406, 410, 412, 418, 431, 440, 441 subpart B and 434 subpart C. The State Authority is 208.151, 208.152, 208.153, 208.166, 167.600 thru 167.621, 191.831 RSMo.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

Each eligible category is forecasted individually. The analysis utilized is listed below:

Permanently and Totally Disabled (PTD)

- Number of eligibles is increased at 0.25% per year (estimated 351 new eligibles) based on historical trends.
- Costs per eligible per month are adjusted by program based on historical trends. Managed Care is excluded due to eligible category involved.
- Total costs for growth in this eligibility group are estimated at \$3.5 million.

1115 Waiver - Adults

- Number of eligibles is increased at 2.58% per year (estimated 324 new eligibles) based on historical trends.
- Costs per eligible per month are adjusted by program based on historical trends.
- Total costs for growth in this eligibility group are estimated at \$52,682.

Medicaid for Pregnant Women (MWP)

- Number of eligibles is increased at 2.12% per year (estimated 112 new FFS and 222 new MC+ eligibles) based on historical trends.
- Costs per eligible per month are adjusted by program based on historical trends.
- Total costs for growth in this eligibility group are estimated at \$2.2 million.

Medicaid For Children (MFC)

- Number of eligibles is increased at 1.95% per year (estimated 1,392 new FFS and 2,156 new MC+ eligibles) based on historical trends.
- Costs per eligible per month are adjusted by program based on historical trends. Buy-In and Nursing Facility are excluded.
- Total costs for growth in this eligibility group are estimated at \$7.9 million.

Total program costs are calculated by adding the program costs for each eligibility category. The total of all new eligibles for the different categories is 4,557: 2,179 new FFS and 2,378 new MC+ eligibles. Anticipated caseload growth results in the following request:

FY 08 Department Request:

Program	General Revenue	Federal	Total
Pharmacy - elderly & disabled	\$468,743	\$771,974	\$1,240,717
Physician - elderly & disabled	\$173,890	\$286,379	\$460,269
Premium Payments - elderly & disabled	\$81,920	\$134,914	\$216,834
Home Health - elderly & disabled	\$3,915	\$6,447	\$10,362
Rehab & Specialty - elderly & disabled	\$50,981	\$83,962	\$134,943
NEMT - elderly & disabled	\$15,228	\$25,080	\$40,308
Hospital - elderly & disabled	\$516,836	\$851,179	\$1,368,015
<i>subtotal elderly & disabled</i>	<u>\$1,311,513</u>	<u>\$2,159,935</u>	<u>\$3,471,448</u>
Pharmacy - adult & kids	\$367,239	\$604,807	\$972,046
Physician - adult & kids	\$440,289	\$725,113	\$1,165,402
Dental - adult & kids	\$26,374	\$43,436	\$69,810
Premium Payments - adult & kids	\$0	\$0	\$0
Home Health - adult & kids	\$380	\$626	\$1,006
Rehab & Specialty - adult & kids	\$28,460	\$46,872	\$75,332
NEMT - adult & kids	\$8,179	\$13,469	\$21,648
Managed Care	\$2,005,901	\$3,303,525	\$5,309,426
Hospital - adult & kids	\$936,877	\$1,542,945	\$2,479,822
1115 Waiver - Adults	\$19,903	\$32,779	\$52,682
<i>subtotal adults & kids</i>	<u>\$3,833,602</u>	<u>\$6,313,572</u>	<u>\$10,147,174</u>
TOTAL	<u><u>\$5,145,115</u></u>	<u><u>\$8,473,507</u></u>	<u><u>\$13,618,622</u></u>

The SFY08 blended federal match rate of 62.22% is used.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.										
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req FTE	GR	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0		0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0			0		0		0		0
Program Distributions	5,145,115			8,473,507		0		13,618,622		
Total PSD	5,145,115			8,473,507		0		13,618,622		0
Transfers										
Total TRF	0			0		0		0		0
Grand Total	5,145,115		0.0	8,473,507	0.0	0	0.0	13,618,622	0.0	0

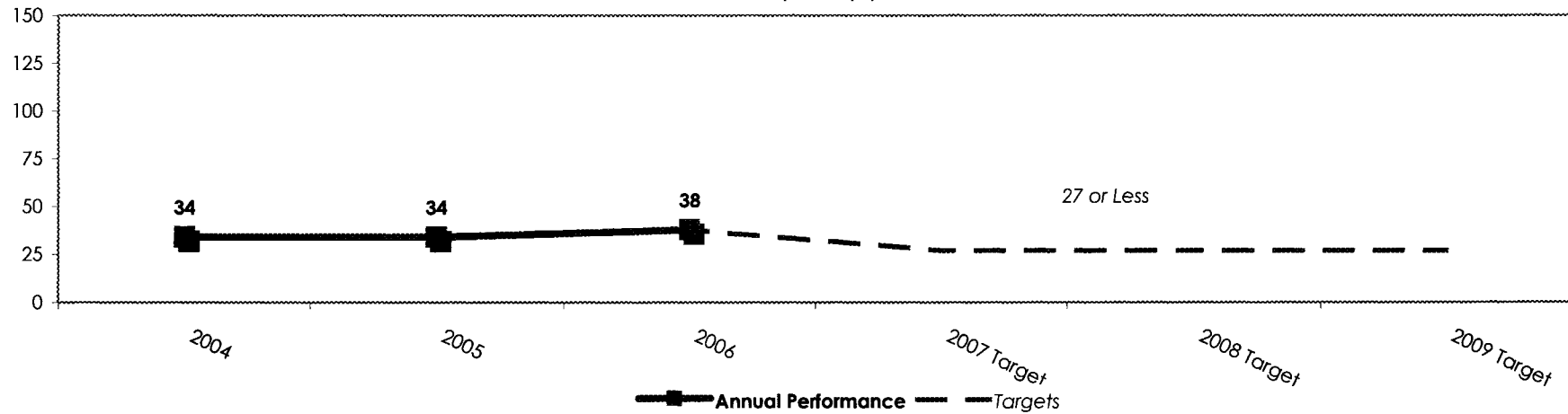
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.										
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec FTE	GR	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0		0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0			0		0		0		0
Program Distributions										0
Total PSD	0		0	0	0	0		0		0
Transfers										
Total TRF	0			0		0		0		0
Grand Total	0		0.0	0	0.0	0	0.0	0	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

Maintain Medicaid Provider Enrollment Application Backlog
(in Days)



6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Eliminate manual processing of provider forms by implementing automated processes.
- Maintain unit staffing.
- Continue to inform providers of their ability to enroll and/or access information including provider manuals, billing booklets and bulletins via the internet through the emomed.com or the Medicaid web site.

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	2,212,763	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	2,212,763	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$2,212,763	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$835,982	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,376,781	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,625,671	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,625,671	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,625,671	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$614,179	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,011,492	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	69,810	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	69,810	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$69,810	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$26,374	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$43,436	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PREMIUM PAYMENTS								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	216,834	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	216,834	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$216,834	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$81,920	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$134,914	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOME HEALTH-PACE								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	11,368	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	11,368	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$11,368	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$4,295	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$7,073	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	210,275	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	210,275	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$210,275	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$79,441	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$130,834	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	61,956	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	61,956	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$61,956	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$23,407	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$38,549	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	5,309,426	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	5,309,426	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$5,309,426	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,005,901	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,303,525	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	3,847,837	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	3,847,837	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$3,847,837	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$1,453,713	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$2,394,124	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
Medicaid Caseload Growth - 1886033								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	52,682	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	52,682	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$52,682	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$19,903	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$32,779	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

**NEW DECISION ITEM
RANK: 14**

Department: Social Services
Division: Medical Services
DI Name: Pharmacy PMPM Increase

Budget Unit: 90541C, 90554C, 90556C, 90585C
DI#: 1886034

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	39,439,051	63,554,489		102,993,540
TRF				
Total	<u>39,439,051</u>	<u>63,554,489</u>		<u>102,993,540</u>

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	29,597,745	47,695,609		77,293,354
TRF				
Total	<u>29,597,745</u>	<u>47,695,609</u>		<u>77,293,354</u>

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: PMPM Increase	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funds to address the anticipated increases in the pharmacy program due to new drugs, therapies and inflation. The request assumes a 15% inflationary factor.

This decision item requests funding for the ongoing inflation of pharmaceuticals. Increase in pharmacy costs continues to grow at a higher rate than other medical costs. This increase can be attributed to the rising cost of drug ingredients, increase in units per prescription, cost of new, expensive medications, and utilization increases. The increase in ingredient costs is due to the inflationary increases which are incorporated into the overall pricing of prescription medications by the pharmaceutical industry as well as the addition of new, expensive agents to the marketplace. The inflation rate requested in this decision item is consistent with the projected inflation rate being projected by all pharmacy payors.

This decision item also seeks funding for the anticipated increase in pharmacy expenditures due to increased utilization. The elderly and persons with disabilities population are utilizing more pharmacy prescriptions each year.

This decision item replaces the Pharmacy Inflation and Pharmacy Utilization decision items that have been requested in previous fiscal years.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts

The methodology for this decision item was computed as follows:

	OAA	% Increase	PTD	% Increase	Other	% Increase	
FY06	\$352.98		\$437.89		\$54.50		
FY07 (Proj)	\$405.93	15.00%	\$503.57	15.00%	\$62.68	15.00%	
FY08 (Proj)	\$466.82	15.00%	\$579.11	15.00%	\$72.08	15.00%	
Increase	\$60.89		\$75.54		\$9.40		
Eligibles	3,628		75,738		280,912		
	220,905		5,720,966		2,640,924		
	12		12		12		Total
Need	\$2,650,866		\$68,651,587		\$31,691,087		\$102,993,540

	Total	GR	Federal
State Medical	\$1,163,827	\$1,163,827	\$0
1115 Waiver - Child	\$1,730,291	\$457,662	\$1,272,629
1115 Waiver - Adult	\$123,592	\$46,693	\$76,899
Pharmacy	\$99,975,830	\$37,770,869	\$62,204,961
Total	\$102,993,540	\$39,439,051	\$63,554,489

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req DOLLARS	GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	39,439,051		63,554,489				102,993,540		
Total PSD	39,439,051		63,554,489		0		102,993,540		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	39,439,051	0.0	63,554,489	0.0	0	0.0	102,993,540	0.0	0

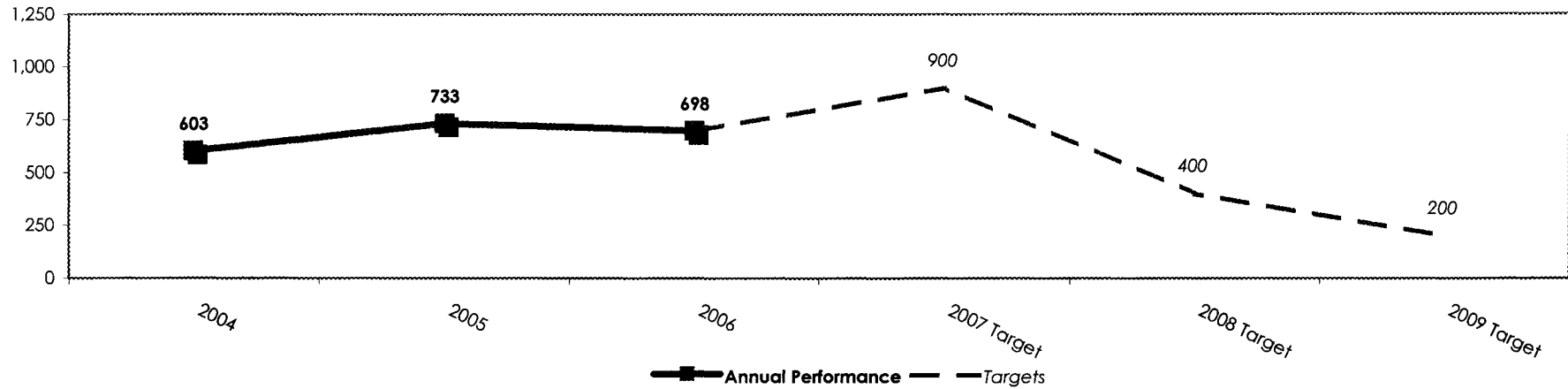
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Gov Rec DOLLARS	GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	29,597,745		47,695,609				77,293,354		
Total PSD	29,597,745		47,695,609		0		77,293,354		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	29,597,745	0.0	47,695,609	0.0	0	0.0	77,293,354	0.0	0

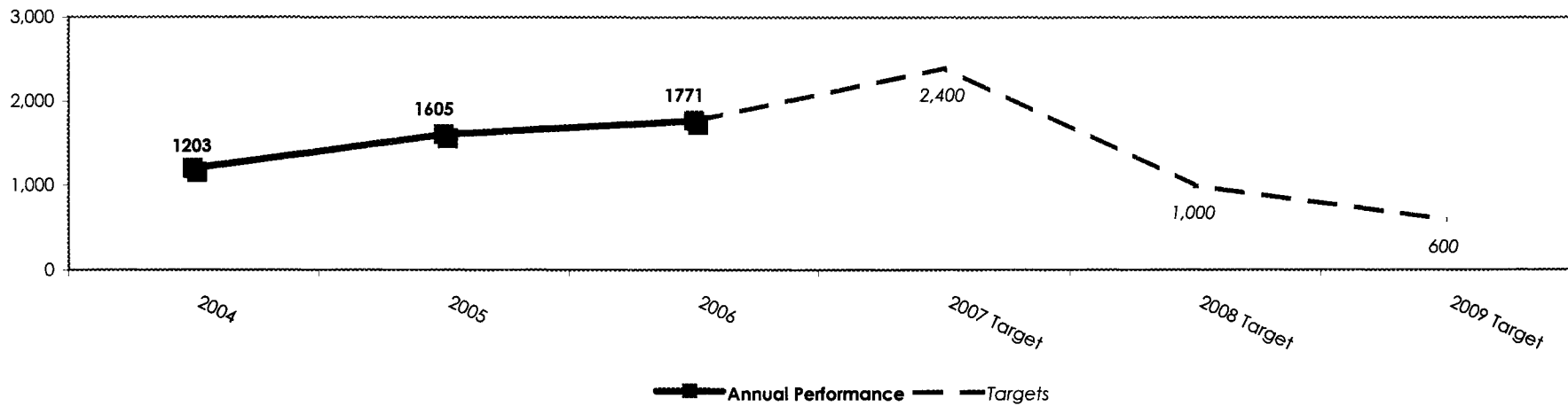
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

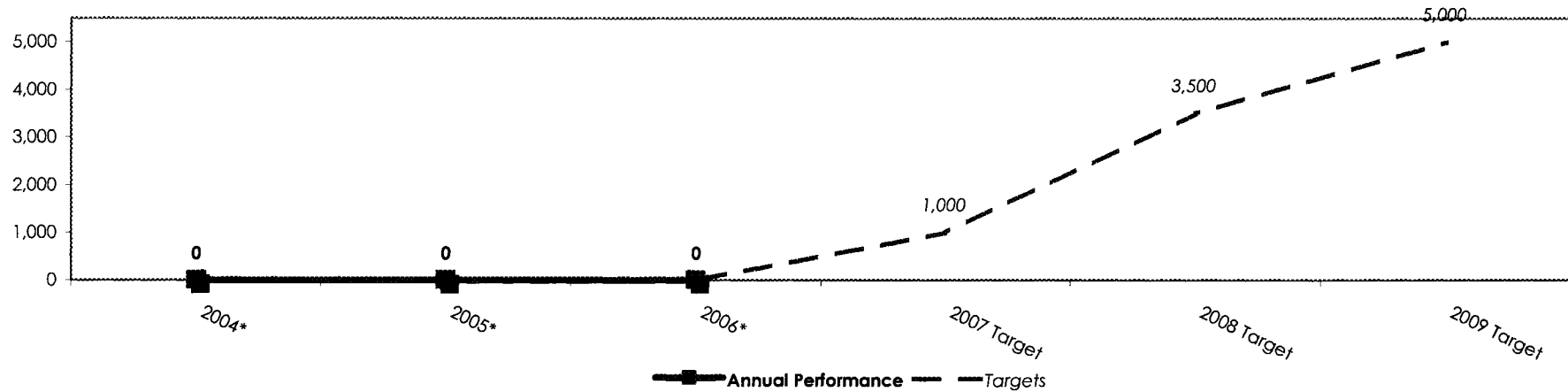
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

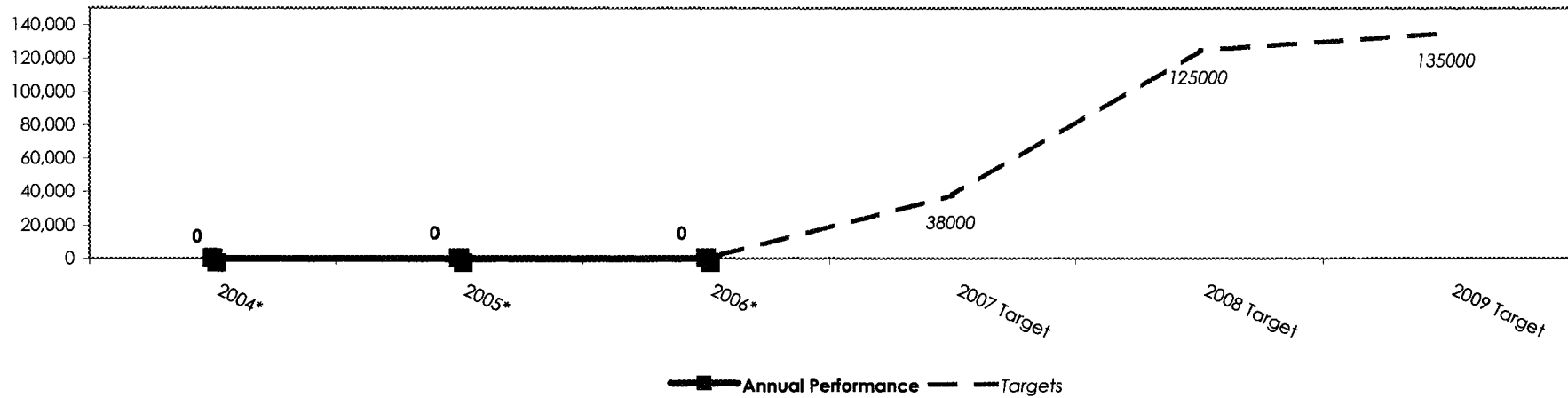


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



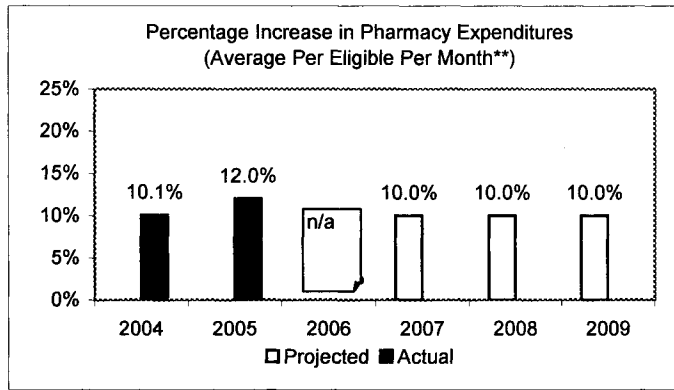
*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,004
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Continue statewide identification of recipients with targeted disease states.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioners.
- Dedicated help desk for recipient support.
- Identify providers currently serving the targeted population to invite them to participate in disease management.
- Continue review, update and implementation of new maximum allowable costs for drug products.
- Continue implementation of clinical edits, prior authorization and step therapy.
- Continue the preferred drug list with accompanying supplemental rebates.
- Continue diabetic supply contracts for cost containment.
- Continue existing cost containment activities.
- Continue implementation of third party liability cost avoidance on pharmacy claims.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of the participation and show providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Pharmacy PMPM Increase - 1886034								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	99,975,830	0.00	75,028,659	0.00
TOTAL - PD	0	0.00	0	0.00	99,975,830	0.00	75,028,659	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$99,975,830	0.00	\$75,028,659	0.00
GENERAL REVENUE								
	\$0	0.00	\$0	0.00	\$37,770,869	0.00	\$28,345,827	0.00
FEDERAL FUNDS								
	\$0	0.00	\$0	0.00	\$62,204,961	0.00	\$46,682,832	0.00
OTHER FUNDS								
	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
Pharmacy PMPM Increase - 1886034								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	123,592	0.00	92,752	0.00
TOTAL - PD	0	0.00	0	0.00	123,592	0.00	92,752	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$123,592	0.00	\$92,752	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$46,693	0.00	\$35,042	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$76,899	0.00	\$57,710	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
Pharmacy PMPM Increase - 1886034								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,730,291	0.00	1,298,528	0.00
TOTAL - PD	0	0.00	0	0.00	1,730,291	0.00	1,298,528	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,730,291	0.00	\$1,298,528	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$457,662	0.00	\$343,461	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,272,629	0.00	\$955,067	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
STATE MEDICAL								
Pharmacy PMPM Increase - 1886034								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,163,827	0.00	873,415	0.00
TOTAL - PD	0	0.00	0	0.00	1,163,827	0.00	873,415	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,163,827	0.00	\$873,415	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$1,163,827	0.00	\$873,415	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

*MANAGED CARE RATE
INCREASE*

**NEW DECISION ITEM
RANK: 18**

Department: Social Services
Division: Medical Services
DI Name: Managed Care Rate Increase

Budget Unit: 90551C, 90556C
DI#: 1886040

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	26,925,817	45,830,628		72,756,445
TRF				
Total	26,925,817	45,830,628		72,756,445
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	26,925,817	45,830,628		72,756,445
TRF				
Total	26,925,817	45,830,628		72,756,445
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

Funding to apply on average an 11% pharmacy inflation increase and an 8% non-pharmacy trend factor for both utilization and cost component increases for drugs and medical services. Funding is for the Eastern, Central, and Western regions for July 2007 through June 2008.

DMS needs to maintain capitation rates at a sufficient level to ensure continued health plan and provider participation. The Federal Authority is Social Security Act Section 1915(b) and 1115 Waiver. The Federal Regulation is 42 CFR 438-Managed Care and the State Authority is 208.166 RSMo. Final rules and regulations published June 14, 2002, effective August 13, 2003, require that capitation payments made on behalf of managed care enrollees be actuarially sound. Further the State must provide the actuarial certification of the capitation rates to the CMS. The CMS Regional Office must review and approve all contracts for managed care as a condition for federal financial participation.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

An average pharmacy inflation increase (11%) and the non-pharmacy utilization and cost component increase (8%) were developed by the Division of Medical Services' actuary. Both utilization and unit cost component increases were included as required by the CMS in developing actuarially sound rates. The pharmacy inflation increase is calculated using a weighted, blended average of the pharmacy component of the capitation rate for all health plans by region. The non-pharmacy utilization and cost component increase is calculated using a weighted, blended average of the capitation rate, less the pharmacy component, for all health plans by region. The numbers used in the column "eligibles" are based on full time equivalents. Full time equivalents approximate 96% of the Managed Care eligibles' count. The cost to continue managed care trend factor need is calculated by region and is based on the number of months in the contract period that fall in FY 2008. The total cost is estimated at \$72,756,445 as follows:

Contract Start Date	Program	Region	1st Period Rate	2nd Period Rate	Difference	Eligibles	Contract Months in FY07	Total
June 1	Managed Care	Eastern-Medical	\$143.37	\$155.99	\$12.62	175,659	12	\$26,601,799
June 1	Managed Care	Eastern-Pharmacy	\$38.03	\$42.97	\$4.94	175,659	12	\$10,413,066
June 1	Managed Care	Central-Medical	\$169.47	\$181.67	\$12.20	45,711	12	\$6,692,090
June 1	Managed Care	Central-Pharmacy	\$48.43	\$52.69	\$4.26	45,711	12	\$2,336,746
June 1	Managed Care	Western-Medical	\$162.90	\$175.12	\$12.22	101,798	12	\$14,927,659
June 1	Managed Care	Western-Pharmacy	\$42.98	\$48.57	\$5.59	101,798	12	\$6,828,610
<i>subtotal Managed Care</i>								<u>\$67,799,970</u>
June 1	1115 Waiver-Child	Eastern-Medical	\$84.27	\$91.43	\$7.16	16,291	12	\$1,399,723
June 1	1115 Waiver-Child	Eastern-Pharmacy	\$33.49	\$37.68	\$4.19	16,291	12	\$819,111
June 1	1115 Waiver-Child	Central-Medical	\$110.04	\$118.40	\$8.36	5,737	12	\$575,536
June 1	1115 Waiver-Child	Central-Pharmacy	\$38.10	\$41.41	\$3.31	5,737	12	\$227,874
June 1	1115 Waiver-Child	Western-Medical	\$116.31	\$125.50	\$9.19	11,538	12	\$1,272,411
June 1	1115 Waiver-Child	Western-Pharmacy	\$38.20	\$42.98	\$4.78	11,538	12	\$661,820
<i>subtotal 1115 Waiver Children</i>								<u>\$4,956,475</u>
Total Need								<u><u>\$72,756,445</u></u>

	Total	GR	Federal
Managed Care	\$67,799,970	\$25,614,829	\$42,185,141
1115 Waiver - Child	\$4,956,475	\$1,310,988	\$3,645,487
	<u>\$72,756,445</u>	<u>\$26,925,817</u>	<u>\$45,830,628</u>

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	26,925,817		45,830,628				72,756,445		
Total PSD	26,925,817		45,830,628		0		72,756,445		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	26,925,817	0.0	45,830,628	0.0	0	0.0	72,756,445	0.0	0

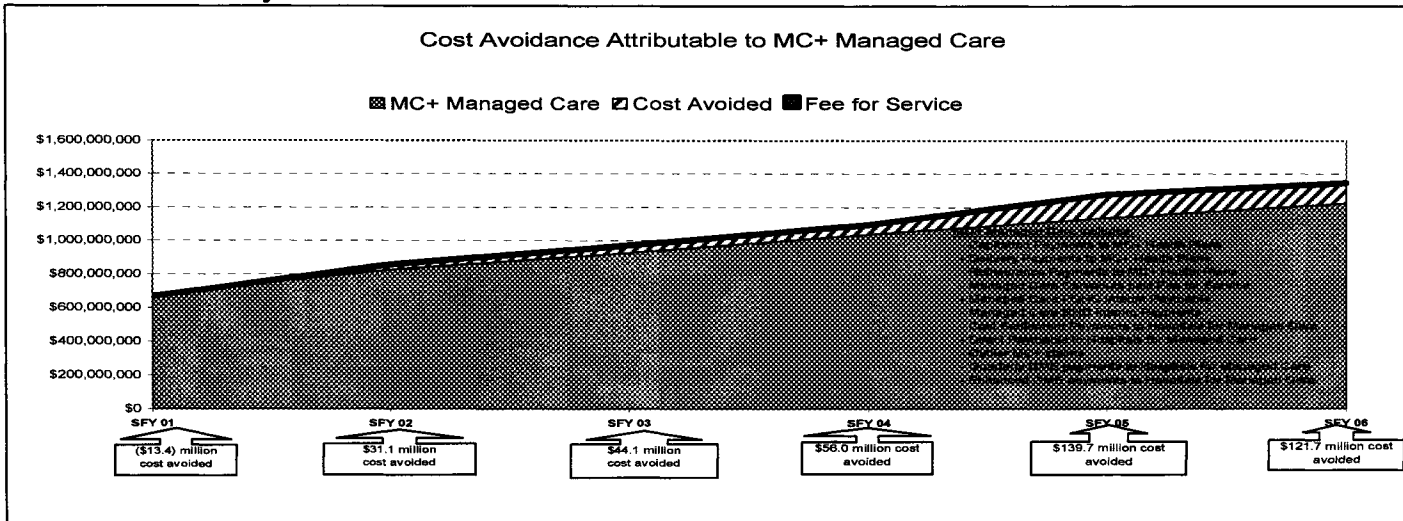
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	26,925,817		45,830,628				72,756,445		
Total PSD	26,925,817		45,830,628		0		72,756,445		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	26,925,817	0.0	45,830,628	0.0	0	0.0	72,756,445	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

See separate document "Since MC+ Began..." included in the Managed Care Program Description.

6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

Managed Care Enrollees		
SFY	Actual	Projected
2004	432,339	
2005	426,873	
2006	379,795	439,679
2007		371,895
2008		356,734
2009		349,314

6d. Provide a customer satisfaction measure, if available.

See separate document "2005 Consumer's Guide MC+ Managed Care in Missouri" included in the Managed Care Program Description.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Participate in the Statewide Coalition, consisting of leaders from Missouri Hospital Association and the Family and Community Trust, to provide outreach and enrollment.
- Purchase cost effective health insurance policies for Medicaid recipients through the Health Insurance Premium Payment Program.
- Continue to work with community groups, local medical providers, health care associations, schools, etc. regarding access to Medicaid coverage.
- Continue to work with MC+ managed care health plans to provide outreach and education to communities regarding access to MC+ coverage.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Managed Care Rate Increase - 1886040								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	67,799,970	0.00	67,799,970	0.00
TOTAL - PD	0	0.00	0	0.00	67,799,970	0.00	67,799,970	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$67,799,970	0.00	\$67,799,970	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$25,614,829	0.00	\$25,614,829	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$42,185,141	0.00	\$42,185,141	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
Managed Care Rate Increase - 1886040								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	4,956,475	0.00	4,956,475	0.00
TOTAL - PD	0	0.00	0	0.00	4,956,475	0.00	4,956,475	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$4,956,475	0.00	\$4,956,475	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$1,310,988	0.00	\$1,310,988	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,645,487	0.00	\$3,645,487	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 23**

Department: Social Services
Division: Medical Services
DI Name: FMAP

Budget Unit: 90541C, 90544C, 90546C, 90547C, 90564C, 90549C, 90550C,
90561C, 90551C, 90552C, 90554C, 90556C
DI#: 1886035

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	1,194,597	12,028,776		13,223,373
TRF				
Total	<u>1,194,597</u>	<u>12,028,776</u>		<u>13,223,373</u>
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	1,194,597	12,028,776		13,223,373
TRF				
Total	<u>1,194,597</u>	<u>12,028,776</u>		<u>13,223,373</u>
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to address the change in the Federal Medical Assistance Percentage (FMAP). Changes are regular rate from FY07 61.68% blended to 62.22% blended and enhanced rate from 73.18% blended to 73.55% blended.

This funding is requested to compensate for the change in the Federal Medical Assistance Percentage (FMAP). Each year the Centers for Medicare and Medicaid Services (CMS) revises the percentage of Medicaid costs that the federal government will reimburse to each state. Effective October 1, 2007, the regular FMAP rate will increase to 62.42% from 61.60%. The enhanced FMAP rate for the 1115 Waiver CHIP children will increase from 73.12% to 73.69%. As a result, the Division of Medical Services seeks to continue program core funding at current levels by compensating for this change in federal funding levels. The increased costs of this decision item have an equal offset in the affected program cores as core reductions. The Federal Authority is Social Security Act 1905(b).

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

Since the federal fiscal year (FFY) doesn't begin until the second quarter of the state fiscal year (SFY), a SFY blended rate is applied to the SFY core funding. This blended rate is derived by adding the old FFY rate (61.60%) for three months (July thru September) and the new FFY rate (62.42%) for nine months (October thru June) and dividing by 12 months, resulting in a SFY blended rate of 62.22%. This same procedure is applied to the enhanced federal match for the 1115 Waiver CHIP program. The enhanced old FFY rate of 73.12% for three months (July thru September) and the new FFY rate of 73.69% for nine months (October thru June) results in an enhanced SFY blended rate of 73.55%. In order to continue current core funding, these blended rates are applied to the SFY 07 core funding resulting in a revised mix of funding sources while maintaining the same total. Based on the review of all program cores and the change in FMAP, the below increases are needed to maintain total funding at the correct level and have equal offsetting reductions in the applicable program cores.

Program	GR	Federal	Other	Total
Pharmacy	\$925,120	\$0	\$0	\$925,120
Physician	\$0	\$3,868,810	\$0	\$3,868,810
Dental	\$0	\$68,521	\$0	\$68,521
Premium Payments	\$0	\$941,941	\$0	\$941,941
Home Health and Pace	\$0	\$64,439	\$0	\$64,439
Nursing Facility	\$0	\$2,589,714	\$0	\$2,589,714
Rehabilitation and Specialty	\$0	\$133,153	\$0	\$133,153
Non-Emergency Transportation	\$212,312	\$0	\$0	\$212,312
Managed Care	\$57,165	\$0	\$0	\$57,165
Hospital	\$0	\$3,755,965	\$0	\$3,755,965
Health Care Access (1115 Waiver Adults)	\$0	\$15,945	\$0	\$15,945
CHIP (1115 Waiver Children)	\$0	\$590,288	\$0	\$590,288
Total FMAP Adjustment	\$1,194,597	\$12,028,776	\$0	\$13,223,373

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	1,194,597		12,028,776				13,223,373		
Total PSD	1,194,597		12,028,776		0		13,223,373		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	1,194,597	0.0	12,028,776	0.0	0	0.0	13,223,373	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	1,194,597		12,028,776				13,223,373		
Total PSD	1,194,597		12,028,776		0		13,223,373		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	1,194,597	0.0	12,028,776	0.0	0	0.0	13,223,373	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

	Regular FFP Rates		Enhanced FFP Rates (CHIP Program)	
	FFY	SFY	FFY	SFY
2004	61.47%	61.41%	73.03%	72.99%
2005	61.15%	61.23%	72.81%	72.87%
2006	61.93%	61.74%	73.35%	73.22%
2007	61.60%	61.68%	73.12%	73.18%
2008	62.42%	62.22%	73.69%	73.55%
2009	62.42%	62.22%	73.69%	73.55%

Since the FMAP adjustments represent a funding source rather than a particular program, measures for the FMAP adjustments are incorporated into the specific Medicaid program sections.

6b. Provide an efficiency measure.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

·Maintain flow of federal financial participation in the healthcare arena. (Beyond DSS)

·The Division of Medical Services (DMS) performs detailed projections for all program cores. These projections include adjusting the federal participation level to the percentage in effect for SFY07. After adjusting the funding sources, the appropriate core funds are reduced through core reductions (see Program Core Requests). Increases in funding are requested through this decision item. These two offsetting actions result in continued core funding at current levels.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	925,120	0.00	925,120	0.00
TOTAL - PD	0	0.00	0	0.00	925,120	0.00	925,120	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$925,120	0.00	\$925,120	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$925,120	0.00	\$925,120	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	3,868,810	0.00	3,868,810	0.00
TOTAL - PD	0	0.00	0	0.00	3,868,810	0.00	3,868,810	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$3,868,810	0.00	\$3,868,810	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,868,810	0.00	\$3,868,810	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	68,521	0.00	68,521	0.00
TOTAL - PD	0	0.00	0	0.00	68,521	0.00	68,521	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$68,521	0.00	\$68,521	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$68,521	0.00	\$68,521	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PREMIUM PAYMENTS								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	941,941	0.00	941,941	0.00
TOTAL - PD	0	0.00	0	0.00	941,941	0.00	941,941	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$941,941	0.00	\$941,941	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$941,941	0.00	\$941,941	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	2,589,714	0.00	2,589,714	0.00
TOTAL - PD	0	0.00	0	0.00	2,589,714	0.00	2,589,714	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$2,589,714	0.00	\$2,589,714	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$2,589,714	0.00	\$2,589,714	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOME HEALTH-PACE								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	64,439	0.00	64,439	0.00
TOTAL - PD	0	0.00	0	0.00	64,439	0.00	64,439	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$64,439	0.00	\$64,439	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$64,439	0.00	\$64,439	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	133,153	0.00	133,153	0.00
TOTAL - PD	0	0.00	0	0.00	133,153	0.00	133,153	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$133,153	0.00	\$133,153	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$133,153	0.00	\$133,153	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	212,312	0.00	212,312	0.00
TOTAL - PD	0	0.00	0	0.00	212,312	0.00	212,312	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$212,312	0.00	\$212,312	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$212,312	0.00	\$212,312	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	57,165	0.00	57,165	0.00
TOTAL - PD	0	0.00	0	0.00	57,165	0.00	57,165	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$57,165	0.00	\$57,165	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$57,165	0.00	\$57,165	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	3,755,965	0.00	3,755,965	0.00
TOTAL - PD	0	0.00	0	0.00	3,755,965	0.00	3,755,965	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$3,755,965	0.00	\$3,755,965	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,755,965	0.00	\$3,755,965	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	15,945	0.00	15,945	0.00
TOTAL - PD	0	0.00	0	0.00	15,945	0.00	15,945	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$15,945	0.00	\$15,945	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$15,945	0.00	\$15,945	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
FMAP - 1886035								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	590,288	0.00	590,288	0.00
TOTAL - PD	0	0.00	0	0.00	590,288	0.00	590,288	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$590,288	0.00	\$590,288	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$590,288	0.00	\$590,288	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Medical for Foster Children

Budget Unit: 90541C, 90544C, 90546C, 90550C, 90561C, 90551C, 90552C
DI#: 1886057

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	632,123	1,041,044		1,673,167
TRF				
Total	632,123	1,041,044		1,673,167
FTE				

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input checked="" type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

Currently foster care youth who leave the custody of the Missouri's Children's Division are not able to access or may not qualify for Missouri Medicaid. These children may no longer have the availability of health care services or medications necessary to maintain a successful level of functioning. Youth leaving foster care at age eighteen, seeking to make the transition to adulthood, often lack supports (such as health care services), and these youth are therefore less likely to successfully meet their own basic life care needs.

The Foster Care Independence Act of 1999, Subtitle C, section 121 of P.L. 106-169, permits states to expand Medicaid eligibility for youth transitioning from foster care. A state may provide Medicaid to all young people under the age of 21 who were in foster care, under the responsibility of the State, on their eighteenth birthday.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The DSS Children's Division projected 970 children would remain Medicaid eligible if the eligibility was extended. The estimate includes those who are fee-for-service and those who would receive service through managed care. This breakdown was based on the current number of foster care individuals between the ages of 18 and 20 who are in managed care or fee-for-service. The projected eligibles was multiplied by the average cost per eligible to arrive at the cost.

	Total	GR	Federal
Pharmacy	\$209,950	\$79,319	\$130,631
Physician	\$760,961	\$287,491	\$473,470
Dental	\$4,345	\$1,642	\$2,703
Rehab & Specialty	\$7,283	\$2,752	\$4,531
NEMT	\$8,395	\$3,172	\$5,223
Managed Care	\$440,790	\$166,530	\$274,260
Hospital	\$241,443	\$91,217	\$150,226
Total	\$1,673,167	\$632,123	\$1,041,044

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	632,123		1,041,044				1,673,167		
Total PSD	632,123		1,041,044		0		1,673,167		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	632,123	0.0	1,041,044	0.0	0	0.0	1,673,167	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	209,950	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	209,950	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$209,950	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$79,319	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$130,631	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	760,961	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	760,961	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$760,961	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$287,491	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$473,470	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	4,345	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	4,345	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$4,345	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$1,642	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$2,703	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	7,283	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,283	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$7,283	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$2,752	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$4,531	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	8,395	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	8,395	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$8,395	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$3,172	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$5,223	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	440,790	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	440,790	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$440,790	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$166,530	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$274,260	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
Medical for Foster Children - 1886057								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	241,443	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	241,443	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$241,443	0.00
GENERAL REVENUE								
	\$0	0.00	\$0	0.00	\$0	0.00	\$91,217	0.00
FEDERAL FUNDS								
	\$0	0.00	\$0	0.00	\$0	0.00	\$150,226	0.00
OTHER FUNDS								
	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

*MEDICAL FOR EMPLOYED
DISABLED*

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Medical for Employed Disabled

Budget Unit: 90541C, 90544C, 90546C, 90549C, 90550C, 90552C

DI#: 1886062

1. AMOUNT OF REQUEST

FY 2008 Budget Request				FY 2008 Governor's Recommendation			
GR	Federal	Other	Total	GR	Fed	Other	Total
PS				PS			
EE				EE			
PSD				PSD	5,070,393	8,350,445	13,420,838
TRF				TRF			
Total			0	Total	5,070,393	8,350,445	13,420,838
FTE			0.00	FTE			0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funds are requested to expand Medicaid eligibility to the employed disabled.

While many people with disabilities fall within the current income levels for Medicaid coverage, more persons with disabilities may increase their earnings or consider returning to work if they are assured Medicaid coverage. Persons with disabilities usually have high medical expenses, and often use long-term support services available under Medicaid. They often do not have access to private health insurance coverage, whether through health insurance or Medicaid. These individuals often cannot afford to pay for their medical care. Under this circumstance, their only alternative may be to stop working, or reduce their work effort, thus reducing their income to a point where they become eligible for Medicaid.

The Balanced Budget Act of 1997 (BBA) section 4733 creates a new optional categorically needy eligibility group. This allows persons to become Medicaid eligible if their family income is less than 250% of the federal poverty level for a family of the size involved and except for their earned income, they would be considered to be receiving SSI benefits. Funds are requested to expand Medicaid eligibility to this group of individuals.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The projected Medicaid eligibles for each month was multiplied by the projected cost per eligible per month to arrive at the annual cost. The projected cost for FY2008 is \$20,213,997. The assumptions and calculations used to arrive at the projected FY08 \$20,213,997 cost is from fiscal note 5088-08 (during the 2006 legislative session).

The SFY08 blended federal matching rate of 62.22% is used.

Program	GR	Federal	Other	Total
Pharmacy	\$2,950,114	\$4,858,553	\$0	\$7,808,667
Nursing Facilities	\$5,155	\$8,491	\$0	\$13,646
Hospital	\$1,148,250	\$1,891,056	\$0	\$3,039,306
Dental	\$61,865	\$101,885	\$0	\$163,750
Physician	\$583,030	\$960,193	\$0	\$1,543,223
Rehab & Specialty	\$321,979	\$530,267	\$0	\$852,246
Dept. of Health & Senior Services	\$734,880	\$1,210,276	\$0	\$1,945,156
Department of Mental Health	\$1,831,576	\$3,016,427	\$0	\$4,848,003
TOTAL	\$7,636,849	\$12,577,148	\$0	\$20,213,997

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
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Total EE	0		0		0		0		0
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Total PSD	0		0		0		0		0
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Transfers									
Total TRF	0		0		0		0		0

Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0
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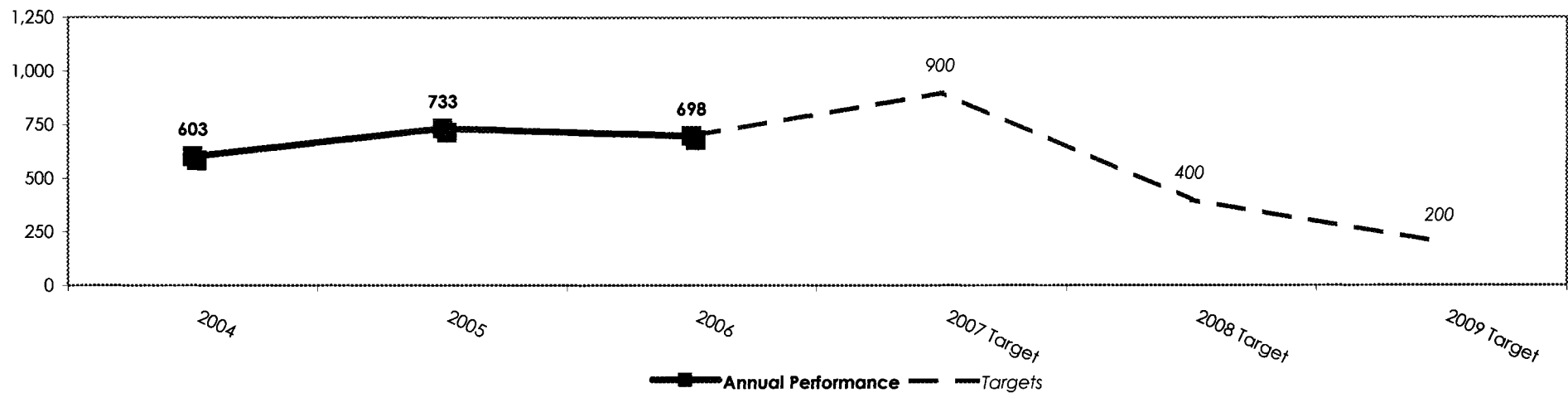
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	5,070,393		8,350,445				13,420,838		
Total PSD	5,070,393		8,350,445		0		13,420,838		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	5,070,393	0.0	8,350,445	0.0	0	0.0	13,420,838	0.0	0

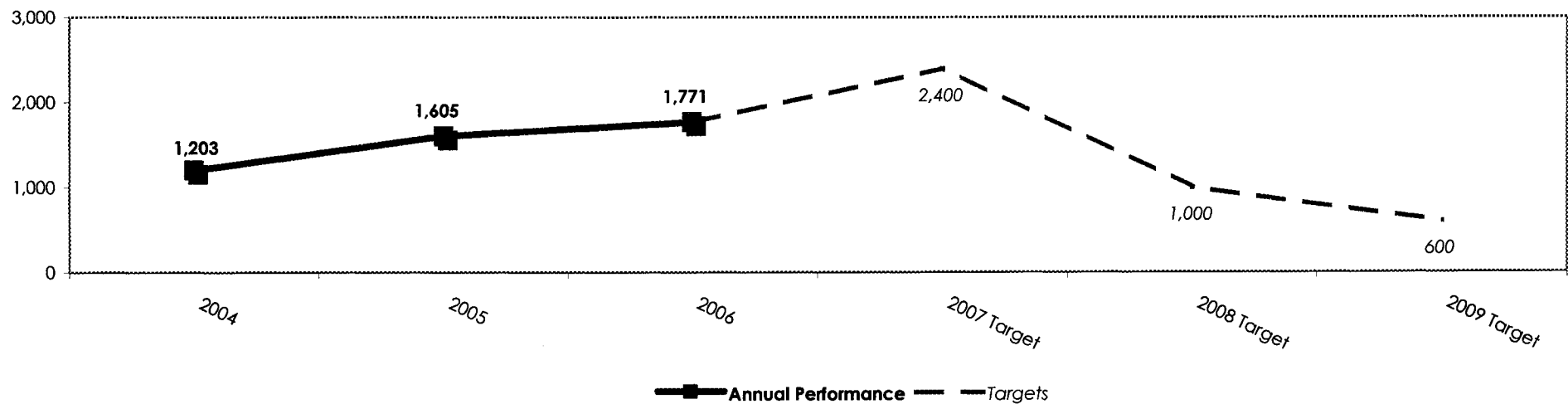
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

Medicaid Providers Participating in Disease Management

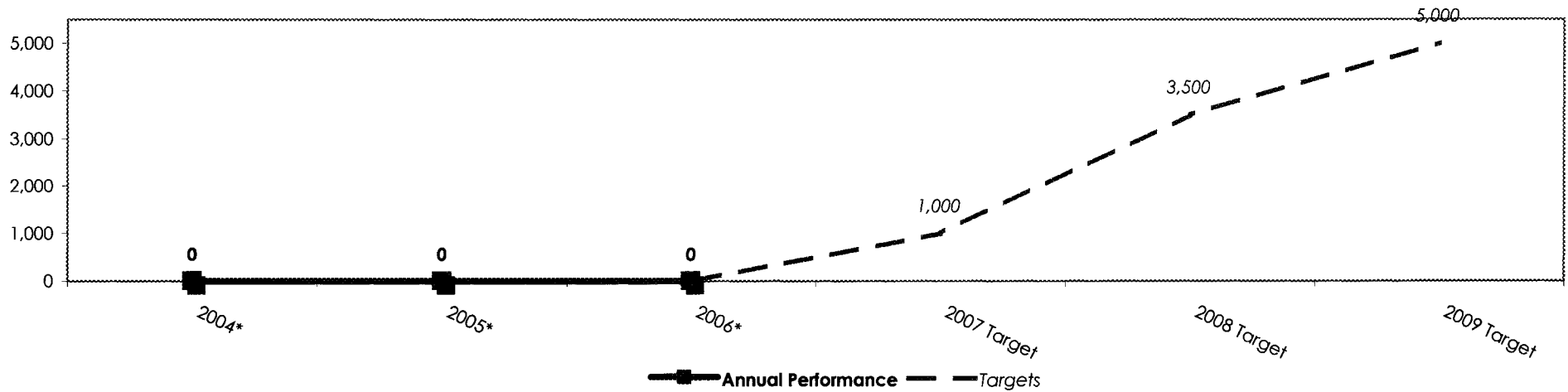


Medicaid/MC+ Recipients in a Disease Management Program



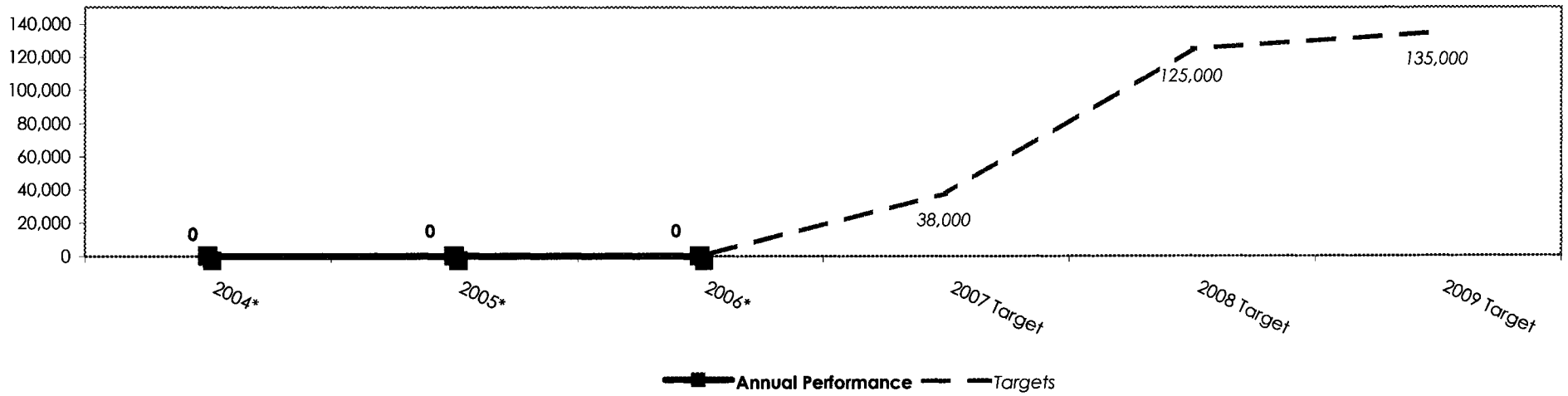
66

Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Work with awarded vendor to establish the Chronic Care Improvement Program (CCIP) for health care management to improve health care quality for patients with chronic illness and disease.
- Maintain the disease management (DM) program and focus on intensive outreach / growing the CCIP.
- Establish dedicated CCIP help desks for provider and recipient support. Continue DM help desks.
- Utilize internet-based plan of care as part of the chronic care improvement program.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioner.
- Continue statewide identification of recipients with targeted disease states.
- Inform providers of the clinical and financial benefits of participating in Disease Management and the Chronic Care Programs.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Expand the number of CyberAccess users and utilize SmartMed™ Prior Authorization for durable medical equipment, and other selected medical procedures.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	7,808,667	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,808,667	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$7,808,667	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$2,950,114	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$4,858,553	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	1,543,223	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	1,543,223	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$1,543,223	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$583,030	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$960,193	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	163,750	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	163,750	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$163,750	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$61,865	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$101,885	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	13,646	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	13,646	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$13,646	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$5,155	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$8,491	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	852,246	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	852,246	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$852,246	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$321,979	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$530,267	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
Medical for Employed Disabled - 1886062								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	3,039,306	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	3,039,306	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$3,039,306	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$1,148,250	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$1,891,056	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Health Risk Appraisals

Budget Unit: 90544C, 90554C, 90556C, 90585C
DI#: 1886060

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	12,135,339	20,489,661		32,625,000
TRF				
Total	12,135,339	20,489,661		32,625,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: To fund an annual health risk assessment for each Medicaid beneficiary.

Under the MO HealthNet program each participant will have a health care home. Participants will choose a primary care provider within the medical home who will educate and foster an ongoing relationship with the participant. The primary care provider will be responsible for developing an electronically-based plan of care based upon the health risk assessment for the participant that will provide the participant, the primary care provider and other providers a roadmap for maintaining or improving the participant's health status. The plan of care will address the appropriate level of care for each participant, as well as govern where participants receive treatment.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The primary care provider in consultation with the participant will complete a health risk assessment annually. The reimbursement rate for the assessment will be \$25.00. The assessment will be billed in addition to an office visit (reimbursement averaging \$50.00). The health risk assessment will be voluntary for the participant. It is estimated that one-half of the participants will choose to have the health risk appraisal. The projected cost is: 435,000 x \$75.00 = \$32,625,000.

	Total	GR	Federal
Physician Related	29,294,640	11,067,515	18,227,125
1115 Waiver - Adults	622,811	235,298	387,513
1115 Waiver - CHIP	2,549,318	674,295	1,875,023
State Medical	158,231	158,231	0
Total	\$32,625,000	\$12,135,339	\$20,489,661

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	12,135,339		20,489,661				32,625,000		
Total PSD	12,135,339		20,489,661		0		32,625,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	12,135,339	0.0	20,489,661	0.0	0	0.0	32,625,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Health Risk Appraisals - 1886060								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	29,294,640	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	29,294,640	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$29,294,640	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$11,067,515	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$18,227,125	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
Health Risk Appraisals - 1886060								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	622,811	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	622,811	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$622,811	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$235,298	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$387,513	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
Health Risk Appraisals - 1886060								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	2,549,318	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,549,318	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$2,549,318	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$674,295	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$1,875,023	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
STATE MEDICAL								
Health Risk Appraisals - 1886060								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	158,231	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	158,231	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$158,231	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$158,231	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

*PHYSICIAN-RELATED RATE
INCREASE*

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Physician-Related Services Rate Increase

Budget Unit: 90544C, 90546C, 90551C, 09554C, 90556C, 90585C

DI#: 1886058

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				0
TRF				
Total	0	0	0	0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	20,000,000	32,896,059		52,896,059
TRF				
Total	20,000,000	32,896,059		52,896,059
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

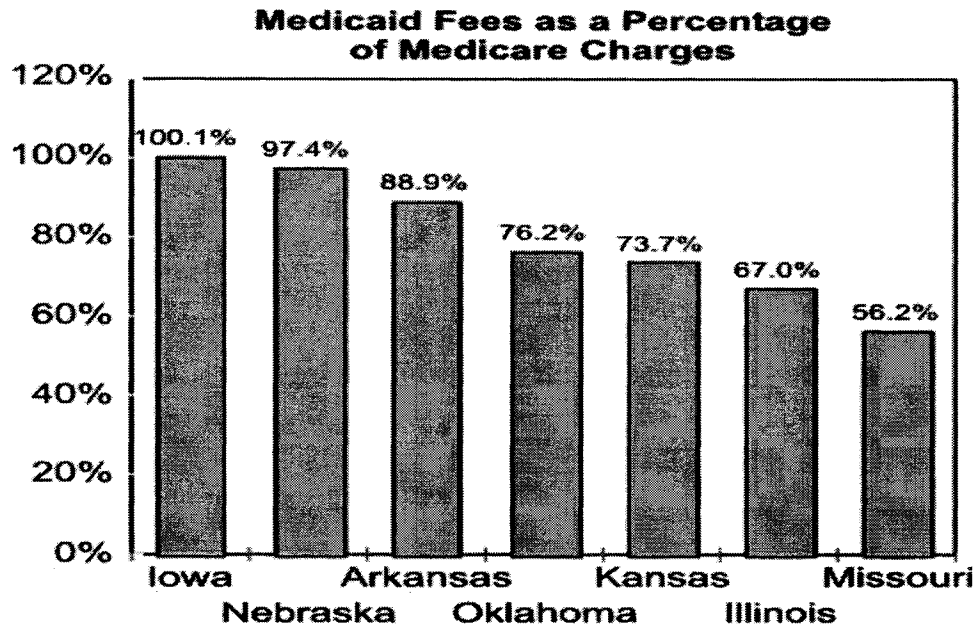
<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Rate Increase	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: To fund a rate increase for physician-related services.

According to a news article published by Health Affairs, Medicaid physician-related fees on average grew at nearly twice the rate of inflation between 1998 and 2003, but they still remain well below the rates paid by Medicare in most parts of the country. Low Medicaid fees discourage providers from accepting Medicaid patients, thereby reducing access to care for enrollees. Surveys of physicians have shown that although a majority of physicians accept Medicaid patients, fewer physicians nationally accept new Medicaid patients than accept other types of insured patients. In addition, findings from the Community Tracking Study (CTS) physician survey show that acceptance of new Medicaid patients is higher in states that have higher Medicaid fees relative to Medicare than in states with lower Medicaid fees. Among all patient care physicians in 2001, 52% in low-fee states were accepting new Medicaid patients, compared with 68% in high-fee states.

Based on The Lewin Study, Comparing Physician and Dentist Fees Among Medicaid Programs, Missouri ranks 47th out of all states when comparing Medicaid rates (as of December 2000) as a percent of Medicare charges. The chart (below) shows how Missouri compares to surrounding states.



Based on Lewin Group Study, June 2001

Funds requested in this decision item provide for increased rates for physician-related services for both fee-for-service and managed care recipients. DMS will amend managed care contracts with health plans for the proposed rate increase. Plans must sign the contract amendment that they will pass the rate increase on to their providers. The Federal Authority is the Social Security Act 1905 (a); 1915(b); and 1115 Waiver. The Federal Regulations are 42 CFR 440.210; 440.500 and 434 Subpart C. The State Authority is 208.152 and 208.166 RSMo.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

□

	Gov Rec		
	Projected Cost	General Revenue	Federal Funds
Physician-Related Services	\$30,291,084	\$11,443,972	\$18,847,112
Dental	\$828,438	\$312,451	\$515,987
State Medical	\$418,313	\$418,313	\$0
Managed Care	\$19,192,001	\$7,248,738	\$11,943,263
1115 Waiver Adults	\$31,422	\$11,871	\$19,551
1115 Waiver Children	\$2,134,801	\$564,655	\$1,570,146
Total Rate Increase	\$52,896,059	\$20,000,000	\$32,896,059

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions							0		
Total PSD	0		0	0	0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

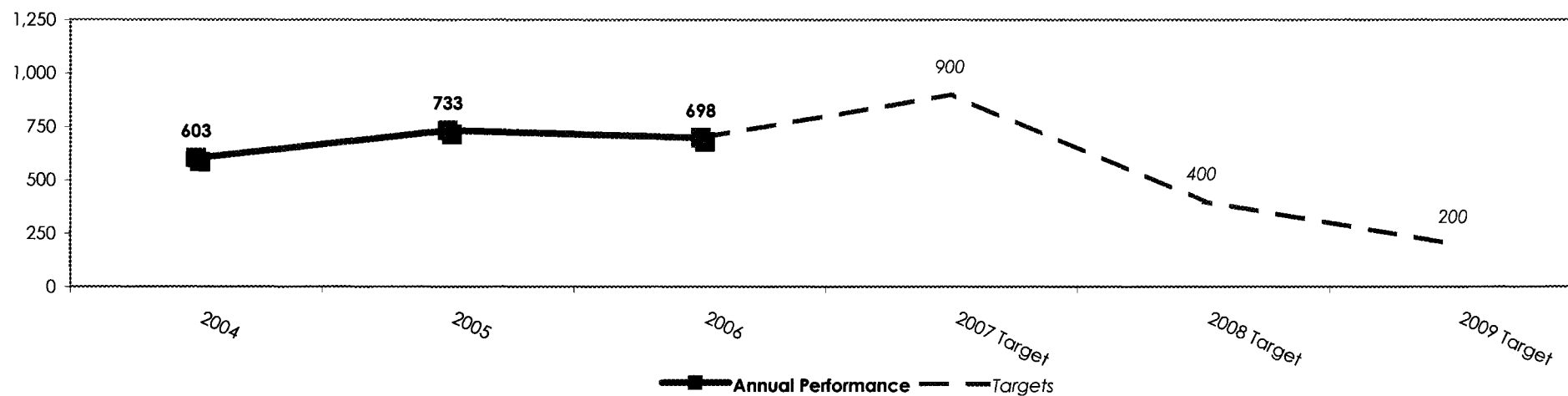
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	20,000,000		32,896,059				52,896,059		
Total PSD	20,000,000		32,896,059		0		52,896,059		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	20,000,000	0.0	32,896,059	0.0	0	0.0	52,896,059	0.0	0

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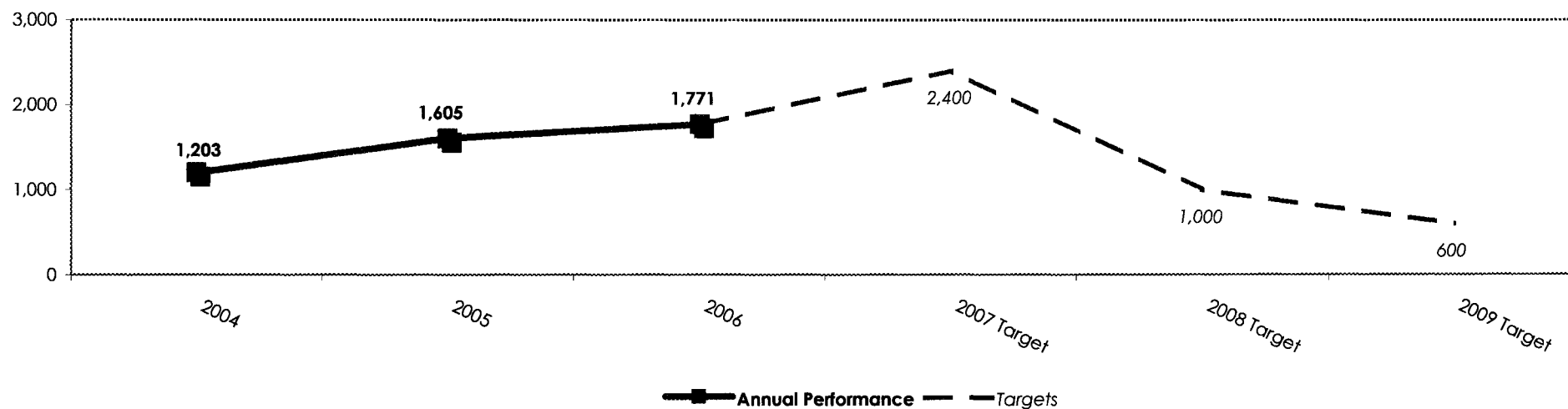
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

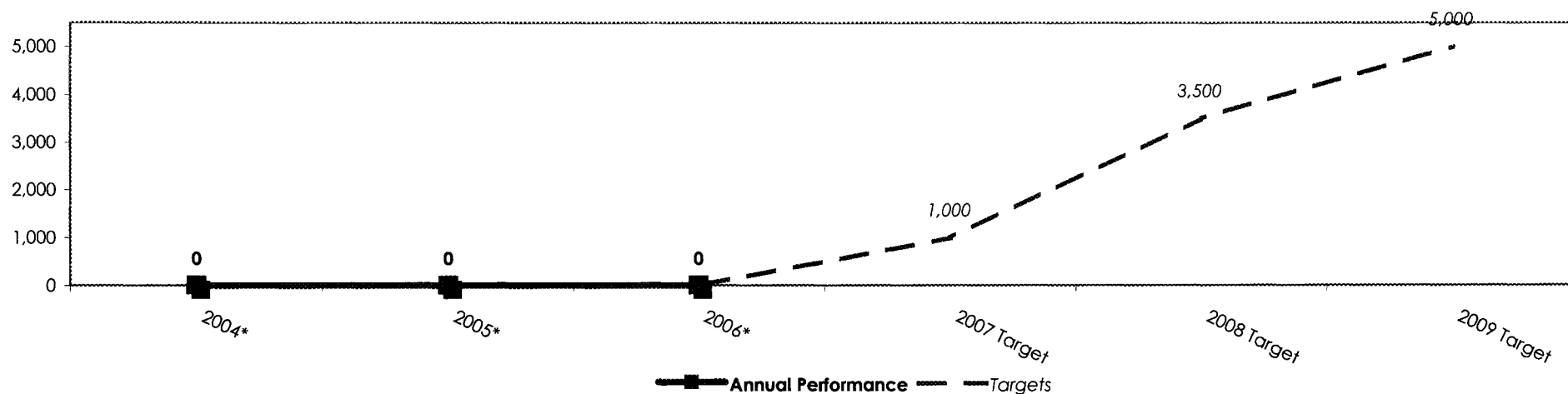
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

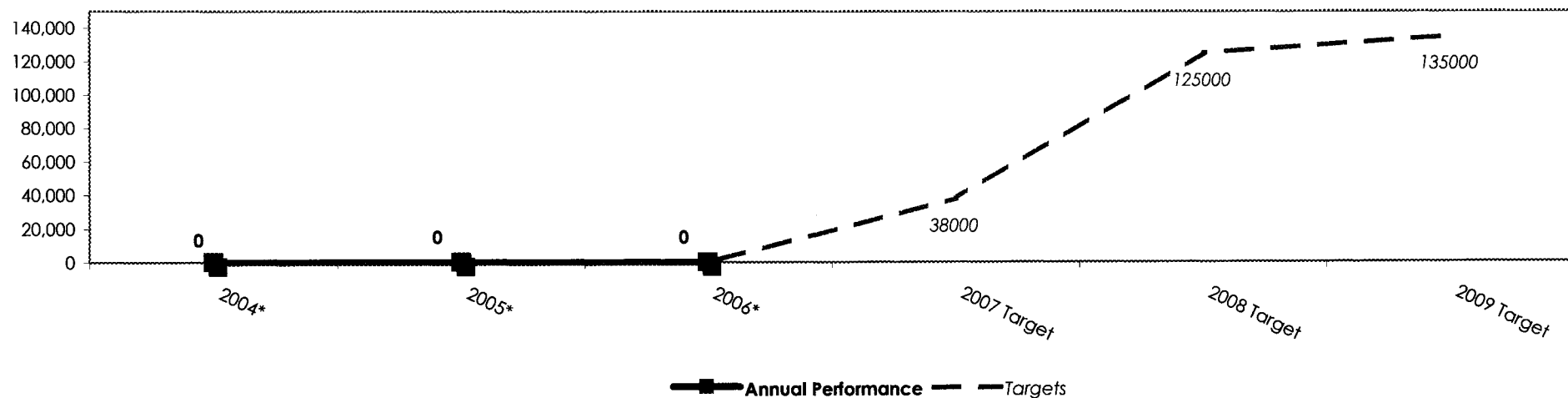


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,055,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

Average Monthly Physician-Related Services Users		
SFY	Actual	Projected
2004	209,756	
2005	232,693	228,424
2006	219,015	233,020
2007		229,966
2008		241,464
2009		253,537

Eligibles:

Physician-related services are available to fee for service Medicaid/MC+ eligibles. In the regions of the state where MC+ managed care has been implemented, enrollees have physician related services available through the MC+ managed care health plan.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Identify providers currently serving the targeted population to invite them to participate in the chronic care improvement program.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of their participation as well as showing providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.
- Evaluate edits causing the largest denials.
- Post on the Internet the most common billing errors and how to avoid them.
- Conduct provider education seminars.
- Assure provider manuals are updated timely.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	30,291,084	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	30,291,084	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$30,291,084	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$11,443,972	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$18,847,112	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	828,438	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	828,438	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$828,438	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$312,451	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$515,987	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	19,192,001	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	19,192,001	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$19,192,001	0.00
GENERAL REVENUE								
	\$0	0.00	\$0	0.00	\$0	0.00	\$7,248,738	0.00
FEDERAL FUNDS								
	\$0	0.00	\$0	0.00	\$0	0.00	\$11,943,263	0.00
OTHER FUNDS								
	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	31,422	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	31,422	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$31,422	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$11,871	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$19,551	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	2,134,801	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,134,801	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$2,134,801	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$564,655	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$1,570,146	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
STATE MEDICAL								
Physician-Related Rate Incr - 1886058								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	418,313	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	418,313	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$418,313	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$418,313	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

NEW DECISION ITEM

RANK: 999

Department: Social Services
Division: Medical Services
DI Name: Provider Tax GR Replacement

Budget Unit: 90541C, 90549C, 90551C, 90552C

DI#: 1886066

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	20,617,580			20,617,580
TRF				
Total	20,617,580			20,617,580
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	20,617,580			20,617,580
TRF				
Total	20,617,580			20,617,580
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input checked="" type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

General Revenue pick-up is requested to keep funding at the current levels as provided by the provider tax programs.

Federal legislation - Tax Relief and Health Care Act - recently passed by Congress and signed by President Bush codifies the maximum Medicaid provider tax rate. Starting January 1, 2008 and through September 30, 2011, the current ceiling of 6 percent is reduced to 5.5 percent.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

Changing the current ceiling from 6 percent to 5.5% will have an impact on Missouri's provider tax programs and the programs funded by the tax. The annual loss totals \$41.2 million. The impact for FY 08 is \$20.6 million because the effective date of the reduction is January 1, 2008. In order to continue providing services at the current level, General Revenue will be needed for the following appropriations. A corresponding core cut from the program's federal reimbursement allowance funds will be made.

Pharmacy	\$ 5,000
Nursing Facilities	\$ 4,231,833
Managed Care	\$ 2,005,809
Hospital	\$ 14,374,938
Total	\$ 20,617,580

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	20,617,580						20,617,580		
Total PSD	20,617,580		0		0		20,617,580		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	20,617,580	0.0	0	0.0	0	0.0	20,617,580	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	20,617,580						20,617,580		
Total PSD	20,617,580		0		0		20,617,580		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	20,617,580	0.0	0	0.0	0	0.0	20,617,580	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

FRA Tax Assessments Revenues Obtained	
SFY	
2004	\$552.3 mil
2005	\$636.1 mil
2006	\$764.3 mil
2007	\$823.4 mil estimated
2008	\$809 mil estimated
2009	\$809 mil estimated

NFRA Tax Assessments Revenues Obtained	
SFY	
2004	\$129.0 mil
2005	\$140.5 mil
2006	\$127.7 mil
2007	\$127.9 mil estimated
2008	\$123.7 mil estimated
2009	\$123.7 mil estimated

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Provider Tax GR Replacement - 1886066								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	5,000	0.00	5,000	0.00
TOTAL - PD	0	0.00	0	0.00	5,000	0.00	5,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$5,000	0.00	\$5,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$5,000	0.00	\$5,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
Provider Tax GR Replacement - 1886066								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	4,231,833	0.00	4,231,833	0.00
TOTAL - PD	0	0.00	0	0.00	4,231,833	0.00	4,231,833	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$4,231,833	0.00	\$4,231,833	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$4,231,833	0.00	\$4,231,833	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Provider Tax GR Replacement - 1886066								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	2,005,809	0.00	2,005,809	0.00
TOTAL - PD	0	0.00	0	0.00	2,005,809	0.00	2,005,809	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$2,005,809	0.00	\$2,005,809	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,005,809	0.00	\$2,005,809	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
Provider Tax GR Replacement - 1886066								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	14,374,938	0.00	14,374,938	0.00
TOTAL - PD	0	0.00	0	0.00	14,374,938	0.00	14,374,938	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$14,374,938	0.00	\$14,374,938	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$14,374,938	0.00	\$14,374,938	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Administration

Budget Unit: 90512C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS	3,208,813	5,207,620	1,425,697	9,842,130
EE	636,173	3,397,397	600,139	4,633,709
PSD		1,030		1,030
TRF				
Total	3,844,986	8,606,047	2,025,836	14,476,869
FTE	85.57	136.55	41.59	263.71

Est. Fringe	1,695,537	2,751,706	753,338	5,200,581
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Pharmacy Rebates Fund (0114)
Pharmacy Reimbursement Allowance Fund (0144)
Health Initiatives Fund (HIF) (0275)
Nursing Facility Quality of Care Fund (NFQC) (0271)
Third Party Liability Collections Fund (TPL) (0120)
MO Rx Plan Fund (0779)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS	3,195,020	5,206,420	1,425,697	9,827,137
EE	636,173	3,397,397	600,139	4,633,709
PSD		1,030		1,030
TRF				
Total	3,831,193	8,604,847	2,025,836	14,461,876
FTE	85.03	136.49	41.59	263.11

Est. Fringe	1,688,249	2,751,072	753,338	5,192,659
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Pharmacy Rebates Fund (0114)
Pharmacy Reimbursement Allowance Fund (0144)
Health Initiatives Fund (HIF) (0275)
Nursing Facility Quality of Care Fund (NFQC) (0271)
Third Party Liability Collections Fund (TPL) (0120)
MO Rx Plan Fund (0779)

2. CORE DESCRIPTION

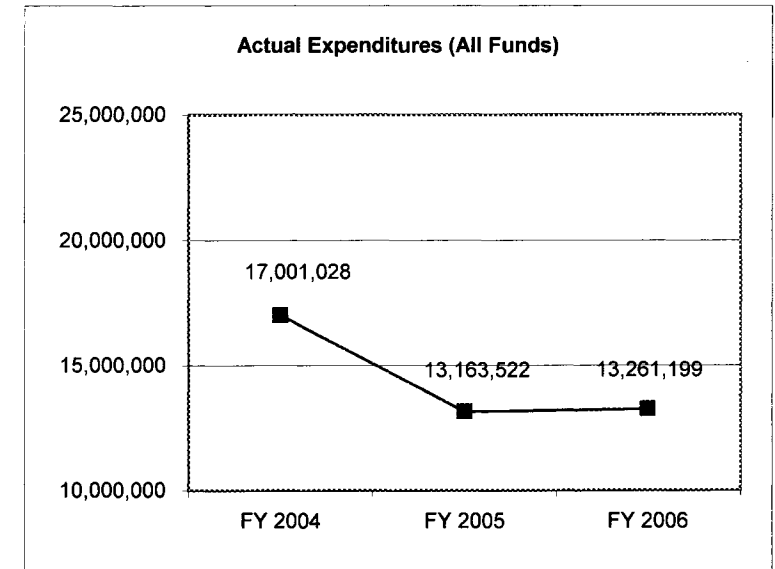
This core request is for the continued operation of the Missouri Medicaid program. The Division of Medical Services seeks to aid recipients and providers in their efforts to access the Medicaid program by utilizing administrative staffing, expense and equipment and contractor resources effectively.

3. PROGRAM LISTING (list programs included in this core funding)

Division of Medical Services Administration

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	19,909,020	13,877,175	13,419,156	14,476,869
Less Reverted (All Funds)	(180,808)	(273,716)	(14,418)	N/A
Budget Authority (All Funds)	19,728,212	13,603,459	13,404,738	N/A
Actual Expenditures (All Funds)	17,001,028	13,163,522	13,261,199	N/A
Unexpended (All Funds)	2,727,184	439,937	143,539	N/A
Unexpended, by Fund:				
General Revenue	116	6,617	50,330	N/A
Federal	1,845,341	426,167	89,909	N/A
Other	881,727	7,153	3,300	N/A
	(1) (2)	(3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Agency reserve of \$1,829,244 in federal funds: \$794,285 in PS; \$1,034,959 in EE; \$1,916,685 empty federal fund authority core cut in FY2005. Agency reserve of \$878,615 in other funds/TPL: \$201,459 in PS; \$677,156 in EE.

(2) Pharmacy Program Management expenditures were part of Medicaid Administration expenditures.

(3) Agency reserve of \$381,459 in federal funds in PS.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

MEDICAL SERVICES ADMIN

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES								
		PS	263.71	3,208,813	5,207,620	1,425,697	9,842,130	
		EE	0.00	636,173	3,397,397	600,139	4,633,709	
		PD	0.00	0	1,030	0	1,030	
		Total	263.71	3,844,986	8,606,047	2,025,836	14,476,869	
DEPARTMENT CORE REQUEST								
		PS	263.71	3,208,813	5,207,620	1,425,697	9,842,130	
		EE	0.00	636,173	3,397,397	600,139	4,633,709	
		PD	0.00	0	1,030	0	1,030	
		Total	263.71	3,844,986	8,606,047	2,025,836	14,476,869	
GOVERNOR'S ADDITIONAL CORE ADJUSTMENTS								
Core Reallocation	3264 6378	PS	(0.06)	0	(1,200)	0	(1,200)	
Core Reallocation	3264 6376	PS	(0.54)	(13,793)	0	0	(13,793)	
NET GOVERNOR CHANGES			(0.60)	(13,793)	(1,200)	0	(14,993)	
GOVERNOR'S RECOMMENDED CORE								
		PS	263.11	3,195,020	5,206,420	1,425,697	9,827,137	
		EE	0.00	636,173	3,397,397	600,139	4,633,709	
		PD	0.00	0	1,030	0	1,030	
		Total	263.11	3,831,193	8,604,847	2,025,836	14,461,876	

FLEXIBILITY REQUEST FORM

BUDGET UNIT NUMBER: 90512C	DEPARTMENT: Social Services
BUDGET UNIT NAME: Administration	DIVISION: Medical Services

1. Provide the amount by fund of personal service flexibility and the amount by fund of expense and equipment flexibility you are requesting in dollar and percentage terms and explain why the flexibility is needed. If flexibility is being requested among divisions, provide the amount by fund of flexibility you are requesting in dollar and percentage terms and explain why the flexibility is needed.

DEPARTMENT REQUEST

Section	PS or E&E	Core	% Flex Requested	Flex Requested Amount
	PS	\$9,842,130	20%	\$1,968,426
	E&E	\$4,633,709	20%	\$926,742
<i>Total Request</i>		\$14,475,839		\$2,895,168

2. Estimate how much flexibility will be used for the budget year. How much flexibility was used in the Prior Year Budget and the Current Year Budget? Please specify the amount.

PRIOR YEAR ACTUAL AMOUNT OF FLEXIBILITY USED	CURRENT YEAR ESTIMATED AMOUNT OF FLEXIBILITY THAT WILL BE USED	BUDGET REQUEST ESTIMATED AMOUNT OF FLEXIBILITY THAT WILL BE USED
\$183,300	House Bill 11.400 language allows for up to 20% flexibility between personal service and equipment and expense. DMS does not have an estimate of the amount of that flexibility that might be used in FY07.	20% flexibility is being requested for FY 08. DMS does not have an estimate of the amount of flexibility that might be used if approved.

3. Please explain how flexibility was used in the prior and/or current years.

PRIOR YEAR EXPLAIN ACTUAL USE	CURRENT YEAR EXPLAIN PLANNED USE
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\$183,300 from PS was used to cover E&E

20% flexibility between personal service and equipment/expense was granted. At this time DMS does not have an estimate of the amount of flexibility that might be used in FY 07.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
CORE								
OFFICE SUPPORT ASST (CLERICAL)	51,323	2.43	75,562	3.00	60,742	2.50	60,742	2.50
SR OFC SUPPORT ASST (CLERICAL)	18,712	0.86	0	0.00	0	0.00	0	0.00
ADMIN OFFICE SUPPORT ASSISTANT	182,293	7.44	232,700	9.00	207,097	8.00	207,097	8.00
OFFICE SUPPORT ASST (KEYBRD)	77,840	3.93	170,861	7.01	143,213	6.01	143,213	6.01
SR OFC SUPPORT ASST (KEYBRD)	327,447	14.86	476,786	18.87	446,031	18.87	446,031	18.87
MAILING EQUIPMENT OPER	10,430	0.40	0	0.00	0	0.00	0	0.00
ACCOUNT CLERK II	123,693	5.46	122,492	4.97	145,692	6.00	145,692	6.00
AUDITOR II	58,837	1.79	187,871	7.24	221,759	7.24	221,759	7.24
AUDITOR I	103,119	3.38	0	0.00	0	0.00	0	0.00
SENIOR AUDITOR	238,596	6.35	275,096	7.00	241,208	6.00	241,208	6.00
AUDITOR III	46,355	1.00	48,210	1.00	0	0.00	0	0.00
ACCOUNTANT I	54,005	2.01	56,165	2.01	56,165	2.01	56,165	2.01
ACCOUNTANT III	150,097	4.00	173,800	4.00	173,800	4.00	173,800	4.00
PERSONNEL OFCR I	36,444	1.00	37,902	1.00	37,902	1.00	37,902	1.00
EXECUTIVE II	31,482	0.99	35,704	1.00	35,704	1.00	35,704	1.00
MANAGEMENT ANALYSIS SPEC II	239,017	5.80	253,524	7.00	253,524	6.00	253,524	6.00
HEALTH PROGRAM REP III	0	0.00	179,836	4.00	104,768	2.00	104,768	2.00
PERSONNEL CLERK	0	0.00	27,881	1.00	27,881	1.00	27,881	1.00
PHYSICIAN III	99,264	1.00	103,235	1.00	103,235	1.00	103,235	1.00
REGISTERED NURSE III	75,660	2.01	89,378	2.00	89,378	2.00	89,378	2.00
REGISTERED NURSE IV	176,584	4.05	199,364	4.00	199,364	4.00	199,364	4.00
REGISTERED NURSE V	51,373	1.00	57,793	1.00	57,793	1.00	57,793	1.00
PHARMACEUTICAL CNSLT	0	0.00	288,496	2.00	277,496	2.00	277,496	2.00
PROGRAM DEVELOPMENT SPEC	376,535	10.20	396,050	10.00	423,050	11.00	423,050	11.00
MEDICAID PROGRAM RELATIONS REP	112,873	2.99	117,500	3.58	117,500	3.00	117,500	3.00
CORRESPONDENCE & INFO SPEC I	680,723	20.91	715,314	21.00	715,314	21.58	715,314	21.58
MEDICAID PHARMACEUTICAL TECH	171,910	5.93	228,659	7.00	228,659	7.00	228,659	7.00
MEDICAID CLERK	342,200	13.53	420,120	15.60	393,135	14.57	393,135	14.57
MEDICAID TECHNICIAN	1,100,574	37.60	1,123,129	39.46	1,194,836	39.96	1,179,843	39.36
MEDICAID SPEC	1,263,962	35.94	1,411,503	37.00	1,446,503	40.00	1,446,503	40.00
MEDICAID UNIT SPV	372,787	8.54	414,378	9.00	462,446	11.00	462,446	11.00
LABORER II	1,201	0.06	0	0.00	0	0.00	0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
CORE								
GRAPHIC ARTS SPEC II	4,682	0.14	0	0.00	0	0.00	0	0.00
FISCAL & ADMINISTRATIVE MGR B1	79,214	1.84	100,719	2.00	140,929	3.00	140,929	3.00
FISCAL & ADMINISTRATIVE MGR B2	117,615	2.21	162,789	3.00	173,789	3.00	173,789	3.00
RESEARCH MANAGER B1	0	0.00	50,232	1.00	50,232	1.00	50,232	1.00
SOCIAL SERVICES MGR, BAND 1	46,680	1.00	46,477	1.00	50,232	1.00	50,232	1.00
SOCIAL SERVICES MNGR, BAND 2	619,872	12.11	733,341	13.02	654,111	12.02	654,111	12.02
DESIGNATED PRINCIPAL ASST DEPT	59,698	0.75	0	0.00	0	0.00	0	0.00
DIVISION DIRECTOR	86,762	0.99	91,727	1.00	91,727	1.00	91,727	1.00
DEPUTY DIVISION DIRECTOR	144,371	1.99	151,408	2.00	77,388	1.00	77,388	1.00
DESIGNATED PRINCIPAL ASST DIV	0	0.00	96,038	2.00	231,915	3.00	231,915	3.00
PROJECT SPECIALIST	0	0.00	67,125	0.00	0	0.00	0	0.00
LEGAL COUNSEL	63,803	0.99	67,454	1.00	67,454	1.00	67,454	1.00
CLERK	28,746	1.54	0	0.00	0	0.00	0	0.00
TYPIST	26,526	1.39	0	0.00	0	0.00	0	0.00
OFFICE WORKER MISCELLANEOUS	4,619	0.24	0	0.00	0	0.00	0	0.00
MISCELLANEOUS TECHNICAL	47,338	1.63	0	0.00	0	0.00	0	0.00
SPECIAL ASST PROFESSIONAL	394,015	4.20	214,651	3.95	365,088	5.95	365,088	5.95
SPECIAL ASST OFFICE & CLERICAL	68,106	1.98	75,070	2.00	75,070	2.00	75,070	2.00
PRINCIPAL ASST BOARD/COMMISSON	0	0.00	65,790	1.00	0	0.00	0	0.00
TOTAL - PS	8,367,383	238.46	9,842,130	263.71	9,842,130	263.71	9,827,137	263.11
TRAVEL, IN-STATE	19,656	0.00	47,752	0.00	47,752	0.00	47,752	0.00
TRAVEL, OUT-OF-STATE	5,635	0.00	8,914	0.00	8,914	0.00	8,914	0.00
FUEL & UTILITIES	6,261	0.00	0	0.00	0	0.00	0	0.00
SUPPLIES	786,826	0.00	568,008	0.00	568,008	0.00	568,008	0.00
PROFESSIONAL DEVELOPMENT	10,441	0.00	10,603	0.00	10,603	0.00	10,603	0.00
COMMUNICATION SERV & SUPP	155,298	0.00	158,807	0.00	158,392	0.00	158,392	0.00
PROFESSIONAL SERVICES	3,797,893	0.00	3,736,808	0.00	3,740,517	0.00	3,740,517	0.00
JANITORIAL SERVICES	1,891	0.00	12,303	0.00	0	0.00	0	0.00
M&R SERVICES	61,020	0.00	72,130	0.00	62,507	0.00	62,507	0.00
OFFICE EQUIPMENT	4,744	0.00	3,965	0.00	3,965	0.00	3,965	0.00
OTHER EQUIPMENT	966	0.00	4,075	0.00	1,000	0.00	1,000	0.00
PROPERTY & IMPROVEMENTS	6,467	0.00	0	0.00	0	0.00	0	0.00

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
CORE								
REAL PROPERTY RENTALS & LEASES	0	0.00	1,930	0.00	1,930	0.00	1,930	0.00
EQUIPMENT RENTALS & LEASES	0	0.00	121	0.00	121	0.00	121	0.00
MISCELLANEOUS EXPENSES	36,718	0.00	8,293	0.00	30,000	0.00	30,000	0.00
TOTAL - EE	4,893,816	0.00	4,633,709	0.00	4,633,709	0.00	4,633,709	0.00
PROGRAM DISTRIBUTIONS	0	0.00	1,030	0.00	1,030	0.00	1,030	0.00
TOTAL - PD	0	0.00	1,030	0.00	1,030	0.00	1,030	0.00
GRAND TOTAL	\$13,261,199	238.46	\$14,476,869	263.71	\$14,476,869	263.71	\$14,461,876	263.11
GENERAL REVENUE	\$3,770,846	84.68	\$3,844,986	85.57	\$3,844,986	85.57	\$3,831,193	85.03
FEDERAL FUNDS	\$8,269,288	133.74	\$8,606,047	136.55	\$8,606,047	136.55	\$8,604,847	136.49
OTHER FUNDS	\$1,221,065	20.04	\$2,025,836	41.59	\$2,025,836	41.59	\$2,025,836	41.59

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Administration

Program is found in the following core budget(s): Administration

1. What does this program do?

PROGRAM SYNOPSIS: These staff administer the Medicaid/MC+ program. This appropriation funds administrative staffing, expense and equipment and contractor resources.

In order to efficiently operate the \$5 billion Missouri Medicaid program, the Division of Medical Services (DMS) effectively utilizes its staff of 263.71 FTE. Without these staff and expense and equipment resources, the Medicaid program would not function. The staff running the Medicaid program account for less than ½% of total state employees while the Medicaid program comprises more than 24% of the total FY 2007 state operating budget of \$20.8 billion. The Administrative portion of the budget (Personal Services and Expense and Equipment) comprises less than 0.3% of the division's total budget. Total clients of the division are approximately 870,997, composed of recipients and providers, for a ratio of 3,254 clients per FTE. The recipients and providers benefit from the assistance of the Division of Medical Services' staff.

Administrative expenditures for the division consist of Personal Services and Expense and Equipment. These expenditures are driven by the operational demands of the Title XIX program and a number of state-only programs. At the present time, the division operates both a fee-for-service program and a managed care program. As of June 2006, there are 376,820 recipients eligible for capitated managed care in the Eastern, Central and Western regions of the state. At the same time, fee-for-service programs with 472,194 Medicaid eligibles are being operated for those not in managed care.

Focus of staff is to ensure eligible recipients receive needed services and providers receive timely and proper payment for services provided. Staff monitor utilization and program compliance of Medicaid providers and recipients to identify Medicaid overpayments and fraud, waste and abuse of Medicaid dollars. A new fraud and abuse detection system, Medstat Advantage Suite, was recently implemented. This will help staff to prevent, identify, and deter fraud and abuse in the Missouri Medicaid program.

Personal Services

To further the goal of making Medicaid an active, rather than passive, participant in health care, DMS needed to transform its organization to a business model. This means becoming a leader in health care finance and health care practices.

To that end, the Division is being restructured into two major sections: (1) Finance and Operations and (2) Clinical Services. The Finance and Operations section will incorporate the newest and best technology to accurately and efficiently pay providers in a paperless environment. Technology will provide a robust reporting function that will be a critical part of the management responsibilities of the agency. The Finance, Information Services and Program Management will comprise the Finance and Operations section. In addition, the Program Integrity, Third Party Liability and Medicare units will be combined into one unit of Program Integrity and Cost Recovery which will also be a part of Finance and Operations.

Program development and policy decisions will come from the Clinical Services section, allowing for policy decisions and processes to be oriented to the health and continuum of care needed by participants. Pharmacy enhancement, exceptions, pharmacy rebate, MoRx plan, psychology program and clinical program development will make-up Clinical Services.

A brief description of the agency's structure follows:

The Administrative Section, which includes the Office of the Director, Deputy Division Directors and Legal Counsel, provides executive management support for the division. The section consists of 7 FTE.

(1) The Finance and Operations Section has a total of 206 FTE, and includes the following:

- * The Finance Section, which consists of Cash Control, Budget, Institutional Reimbursement and Office Services, performs rate setting for institutions and managed care, accounting functions, auditing, premium collections, budgeting and office services. There are 41 FTE performing the Finance Section functions.

- * Program Management Section has the dual responsibility of coordinating service delivery for recipients under both the managed care and fee-for-service programs. In addition, provider relations and recipient services are responsibilities of this section. A total of 72 FTE are assigned to the section's functions.

- * The Information Services Section is responsible for all management information system functions. Provider enrollment is also a responsibility of this section. There are a total of 25 FTE in the section.

- * The Program Integrity and Cost Recovery Section has responsibility for Program Integrity, Third Party Liability, and Medicare buy-in. There are a total of 68 FTE in the section.

(2) The Clinical Services Section has a total of 54 FTE, and includes the following:

- * The Pharmacy Section is responsible for the management of quality assessment, exceptions, rebates and program operations for pharmacy services under both the managed care and fee-for-service programs. There are 38 FTE designated to perform these duties.

- * The Clinical Program Development and the Psychology Program is responsible for program development and policy decisions based on clinical criteria. There are 12 FTE in the section.

- * The Missouri Rx Plan Section is responsible for coordinating pharmaceutical benefits between the Missouri Rx plan and the federal Medicare Part D drug program for Medicare/Medicaid dual eligibles and other elderly and disabled Missourians below 200% of FPL. There are 4 FTE in the section.

Expense and Equipment

The other major category in the Administration Core besides Personal Services is Expense and Equipment (E&E). In the FY 2007 core, it comprises 32% of the total Administration Core of \$14.5 million, or approximately \$4.6 million. Of the total \$4.6 million E & E, almost \$3.7 million, over 80%, is designated for professional services contracts.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.201; Federal law: Social Security Act Section 1902(a)(4); Federal Regulations: 42 CFR, Part 432

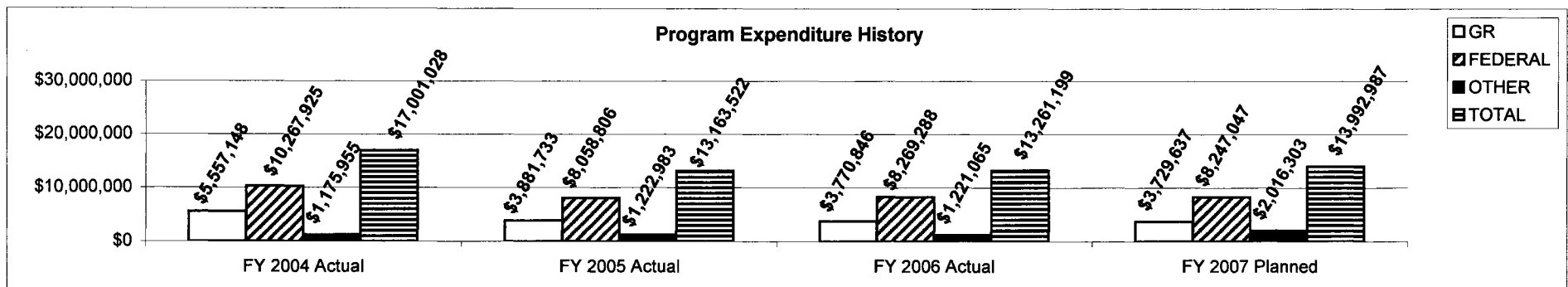
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

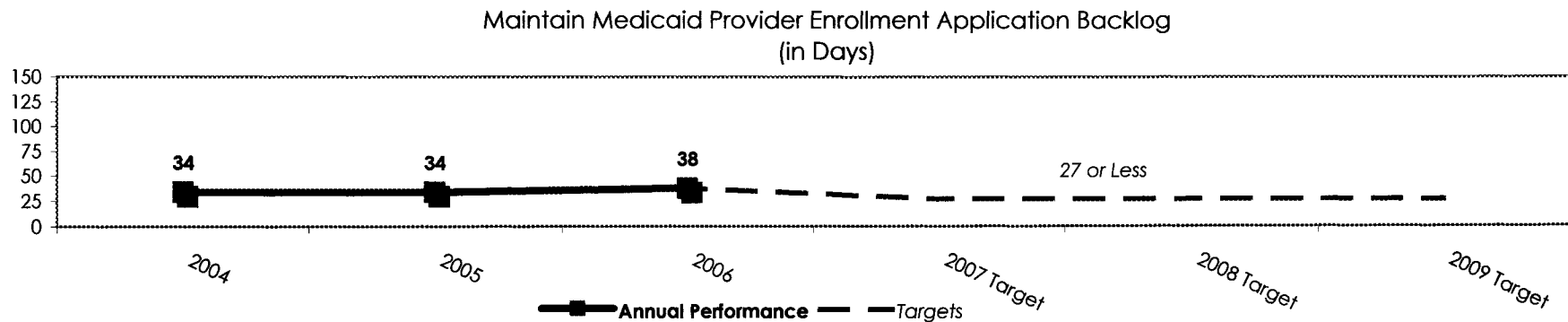


6. What are the sources of the "Other" funds?

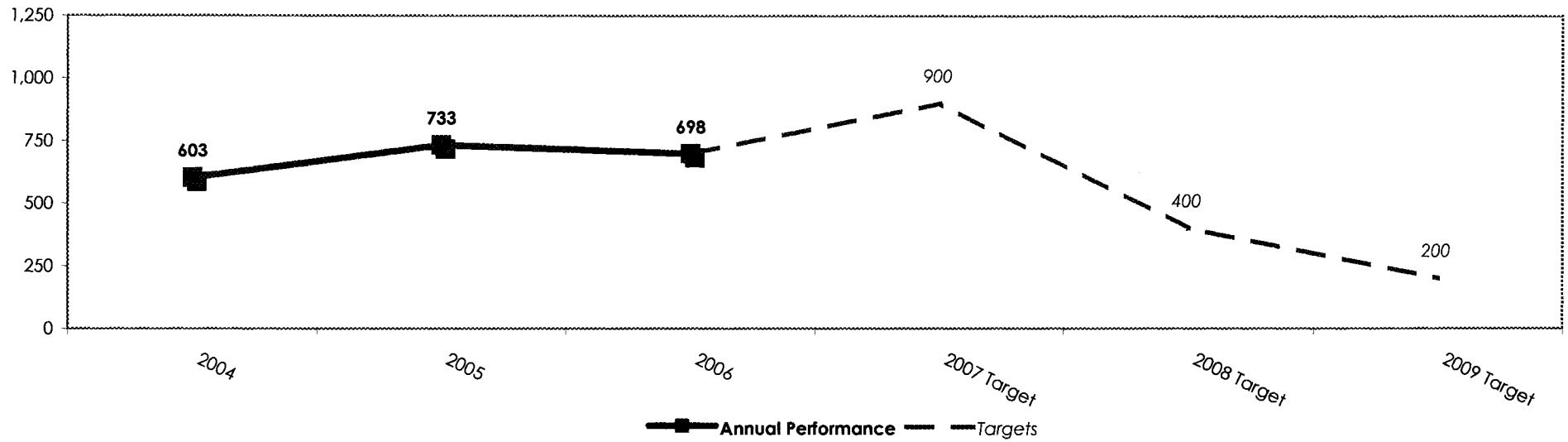
Pharmacy Rebates Fund (0114), Third Party Liability Collections Fund (0120), Nursing Facility Quality of Care Fund (0271), Health Initiatives Fund (0275), Pharmacy Reimbursement Allowance Fund (0144), and Missouri Rx Plan Fund (0779).

7a. Provide an effectiveness measure.

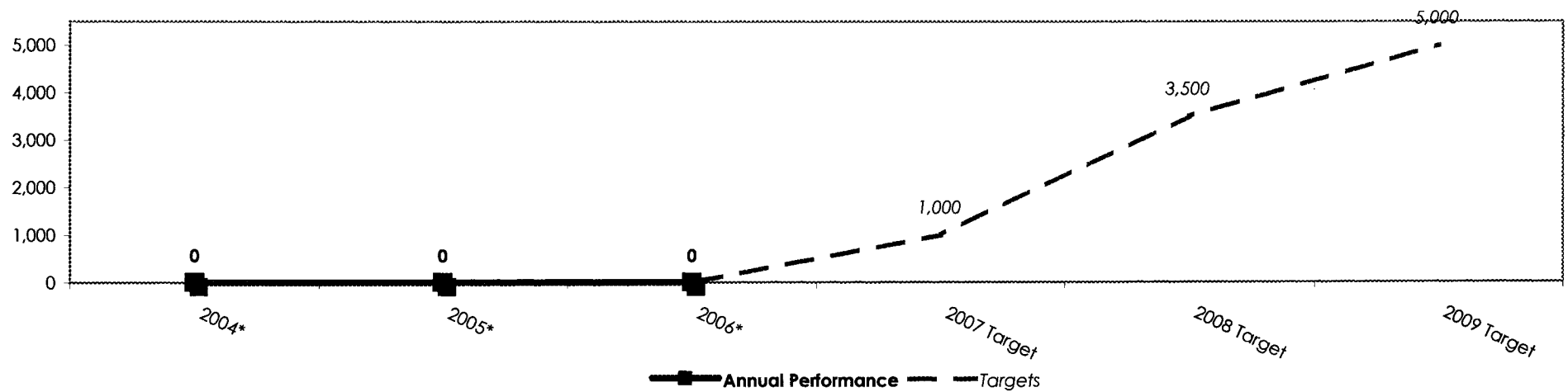
7b. Provide an efficiency measure.



Medicaid Providers Participating in Disease Management



Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

7c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 33**

Department: Social Services
Division: Medical Services
DI Name: Managed Care Expansion Actuarial Study

Budget Unit Number: 90512C
DI#: 1886026

1. AMOUNT OF REQUEST

FY 2007 Budget Request				
	GR	Federal	Other	Total
PS				
EE	207,500	207,500		415,000
PSD				
Total	207,500	207,500		415,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

FY 2007 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE	207,500	207,500		415,000
PSD				
Total	207,500	207,500		415,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Supplemental
<input type="checkbox"/> Federal Mandate	<input checked="" type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: This funding is for rate development to expand Managed Care into contiguous counties.

Funding is requested to complete an actuarial study of the fee-for-service population and their medical and pharmacy utilization and costs for the purpose of setting rates for planned expansion of the Managed Care Program into contiguous counties. Funding is also needed for the education to potential enrollees and to develop a marketing strategy.

The Federal Authority is Social Security Act Section 1915(b) and 1115 Waiver. The Federal Regulation is 42 CFR 438-Managed Care and the State Authority is 208.166 RSMo.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

This funding is for rate development to expand Managed Care into contiguous counties. The administrative costs associated with the expansion include actuary costs for rate setting, recipient notification and system work. The state estimates six months lead time for release and award of a Request for Proposal (RFP) and recipient notification. The actuary cost is based on historical experience. Medicaid administrative expenditures earn a 50% federal match.

Administrative Costs for Expansion	Total	GR	Federal
Actuary costs for rate setting	\$100,000	\$50,000	\$50,000
Recipient notification and system work	\$315,000	\$157,500	\$157,500
	\$415,000	\$207,500	\$207,500

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)	207,500		207,500				415,000		
Total EE	207,500		207,500		0		415,000		0
Total PSD	0		0		0		0		0
Grand Total	207,500	0.0	207,500	0.0	0	0.0	415,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)	207,500		207,500				415,000		
Total EE	207,500		207,500		0		415,000		0
Program Distributions									
Total PSD	0		0		0		0		0
Grand Total	207,500	0.0	207,500	0.0	0	0.0	415,000	0.0	0

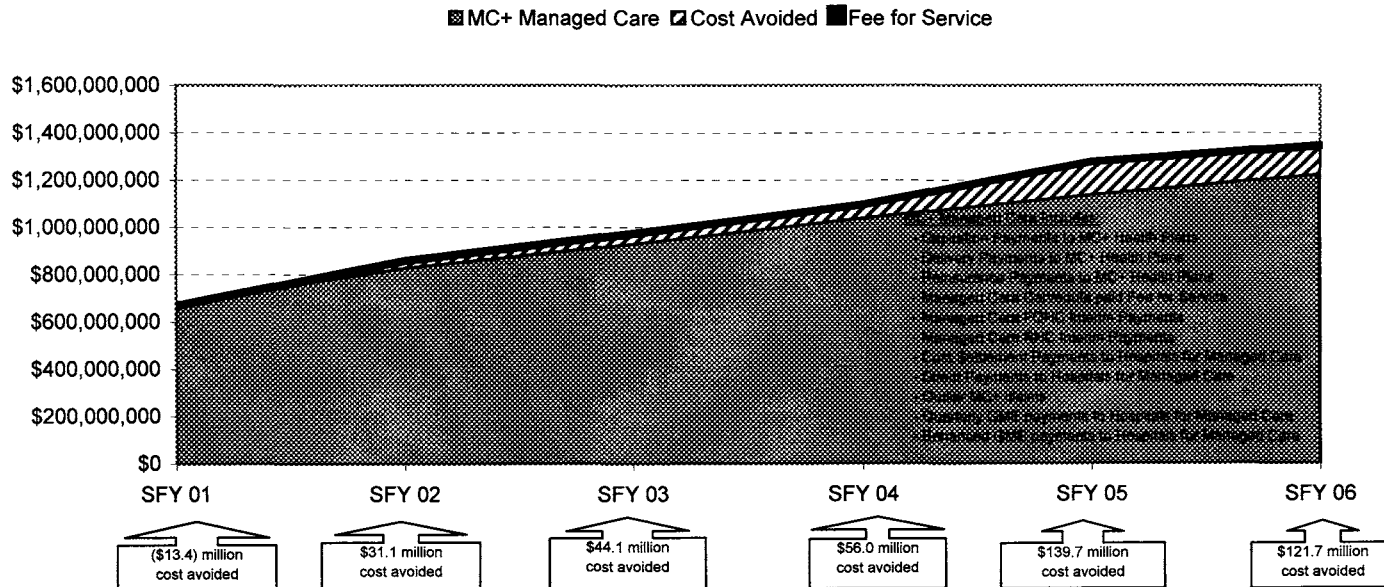
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

See separate document "Since MC+ Began..." included in the Managed Care Program Description.

6b. Provide an efficiency measure.

Cost Avoidance Attributable to MC+ Managed Care



6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

See separate document "2005 Consumer's Guide MC+ Managed Care in Missouri" included in the Managed Care Program Description.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Participate in the Statewide Coalition, consisting of leaders from Missouri Hospital Association and the Family and Community Trust, to provide outreach and enrollment.
- Purchase cost effective health insurance policies for Medicaid recipients through the Health Insurance Premium Payment Program.
- Continue to work with community groups, local medical providers, health care associations, schools, etc. regarding access to Medicaid coverage.
- Continue to work with MC+ managed care health plans to provide outreach and education to communities regarding access to MC+ coverage.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
MC Expansion Actuarial Study - 1886026								
PROFESSIONAL SERVICES	0	0.00	0	0.00	415,000	0.00	415,000	0.00
TOTAL - EE	0	0.00	0	0.00	415,000	0.00	415,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$415,000	0.00	\$415,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$207,500	0.00	\$207,500	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$207,500	0.00	\$207,500	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 36**

Department: Social Services
Division: Medical Services
DI Name: FADS Expansion

Budget Unit: 90512C
DI#: 1886027

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE	250,000	250,000		500,000
PSD				
TRF				
Total	250,000	250,000		500,000
FTE				0.00
Est. Fringe	0	0	0	0

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE	250,000	250,000		500,000
PSD				
TRF				
Total	250,000	250,000		500,000
FTE				0.00
Est. Fringe	0	0	0	0

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input checked="" type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: To expand the current Fraud and Abuse Detection System.

The Fraud and Abuse Detection System (FADS) is currently used by the Program Integrity staff to identify areas for investigations. The expansion will allow for additional analytic consulting services. The goal is to streamline the investigative process and increase the speed with which potential cases move through the process. The Federal Authority is Social Security Act Section 1902(a)(4); 42 CFR Part 432. The State Authority is RSMo. 208.201.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

This NDI would allow the Division of Medical Services (DMS) to expand services above those currently outlined in the Fraud and Abuse Detection System (FADS) contract. The objective of those services is to increase the efficiency and effectiveness of the Program Integrity investigation and recovery process by more fully utilizing the FADS for claims-based investigation and preliminary case development.

Below is the initial estimate of the cost to expand the Fraud and Abuse Detection System.

	Total	GR	Federal
Fraud and Abuse Detection System Expansion	\$500,000	\$250,000	\$250,000

Medicaid administrative expenditures earn a 50% federal match.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)	250,000		250,000				500,000		
Total EE	250,000		250,000		0		500,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	250,000	0.0	250,000	0.0	0	0.0	500,000	0.0	0

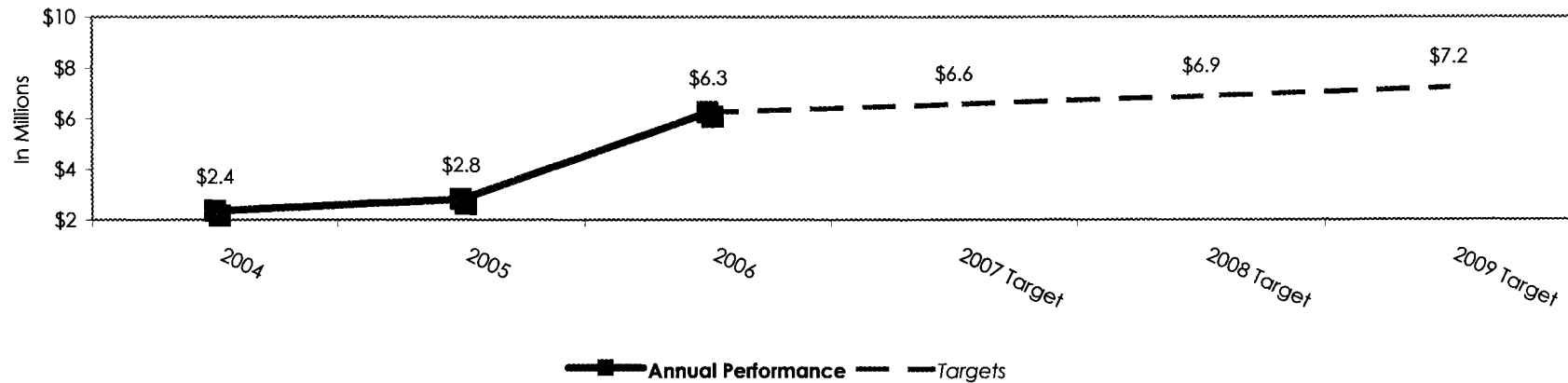
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)	250,000		250,000				500,000		
Total EE	250,000		250,000		0		500,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	250,000	0.0	250,000	0.0	0	0.0	500,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

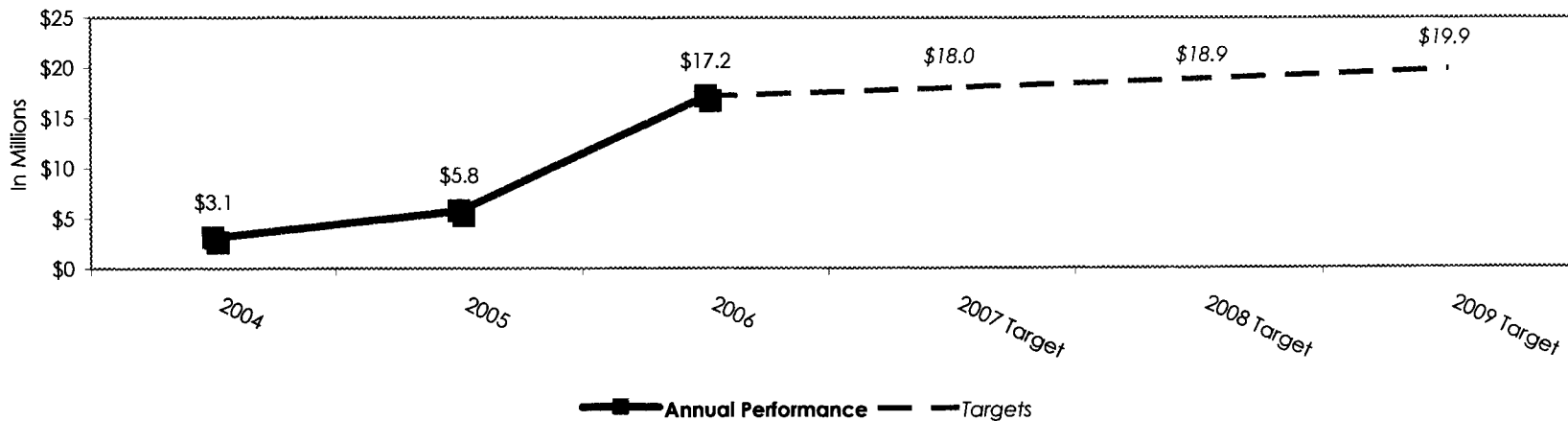
6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

Increase Cost Recoveries From Medicaid Program Integrity



Increase Cost Avoidance From Medicaid Program Integrity



6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Detect fraudulent activities by providers and recipients by exploring addition of prepayment edits similar to the National Correct Coding Initiative.
- Participate in the departmental task force being established to examine areas of fraud, waste and abuse.
- Participate in the federal Payment Error Rate Measurement (PERM) project.
- Develop fraud/abuse algorithms.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
FADS Expansion - 1886027								
PROFESSIONAL SERVICES	0	0.00	0	0.00	500,000	0.00	500,000	0.00
TOTAL - EE	0	0.00	0	0.00	500,000	0.00	500,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$500,000	0.00	\$500,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$250,000	0.00	\$250,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$250,000	0.00	\$250,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 40**

Department: Social Services
Division: Medical Services
DI Name: Investigation Expenses

Budget Unit: 90512C
DI#: 1886028

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	500,000	500,000		1,000,000
PSD				
TRF				
Total	500,000	500,000		1,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

☐ New Legislation
☐ Federal Mandate
☐ GR Pick-Up
☐ Pay Plan

☐ New Program
☐ Program Expansion
☐ Space Request
☒ Other: Travel/Contractor

☐ Fund Switch
☐ Cost to Continue
☐ Equipment Replacement

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

Funding is requested for travel for existing staff and/or contractor for on-site audits and investigations of Medicaid providers. In order to ensure program and operational efficiencies are achieved, on-site reviews and audits of the Medicaid program are needed. Funding for travel is requested so that staff can perform on-site audits for fraud detection and elimination. On-site visits are also needed for staff to perform Nursing Facility rate setting audits. Timely rate setting audits and fraud detection audits are tools used to ensure effective program management.

Funding is also requested for a contractor to implement a Quality Management Strategy for Missouri's seven Medicaid Home and Community Based Services (HCBS) waivers that serve over 30,000 individuals annually. In accordance with 42 CFR §431.10, the Medicaid agency is responsible for ensuring that an HCBS waiver is operated in accordance with applicable federal regulations and the provisions of the waiver itself. While an HCBS waiver may be operated by another state agency, the state Medicaid agency must supervise their performance. The Centers for Medicare and Medicaid (CMS) require the State Medicaid agency to conduct a periodic assessment of the performance of the other state agencies to ensure that the HCBS waiver is operated in accordance with the approved waiver and applicable federal requirements. The new Quality Management Strategy for the HCBS waivers focuses on how the State Medicaid agency will exercise oversight over the performance of the waiver functions (level of care determinations, service plan, qualified providers, health and welfare of waiver participants, administrative authority, and financial accountability) by other state agencies, identifying problems, implementing remedies and requesting evidence of continuous quality improvements. The contractor will develop and implement consistent methods to monitor a full range of operational and administrative responsibilities of the operating agency that meet the oversight responsibilities of the state Medicaid Agency.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

The estimated request is a range of \$100,000 to \$1 million. The range is given so that if a contractor is shown to be the most effective use of resources for the on-site audits, funding will be available.

It is estimated that the contractor for the Home and Community Based Waivers will need approximately five personnel to fulfill this task.

Medicaid administration expenditures receive a 50% federal match.

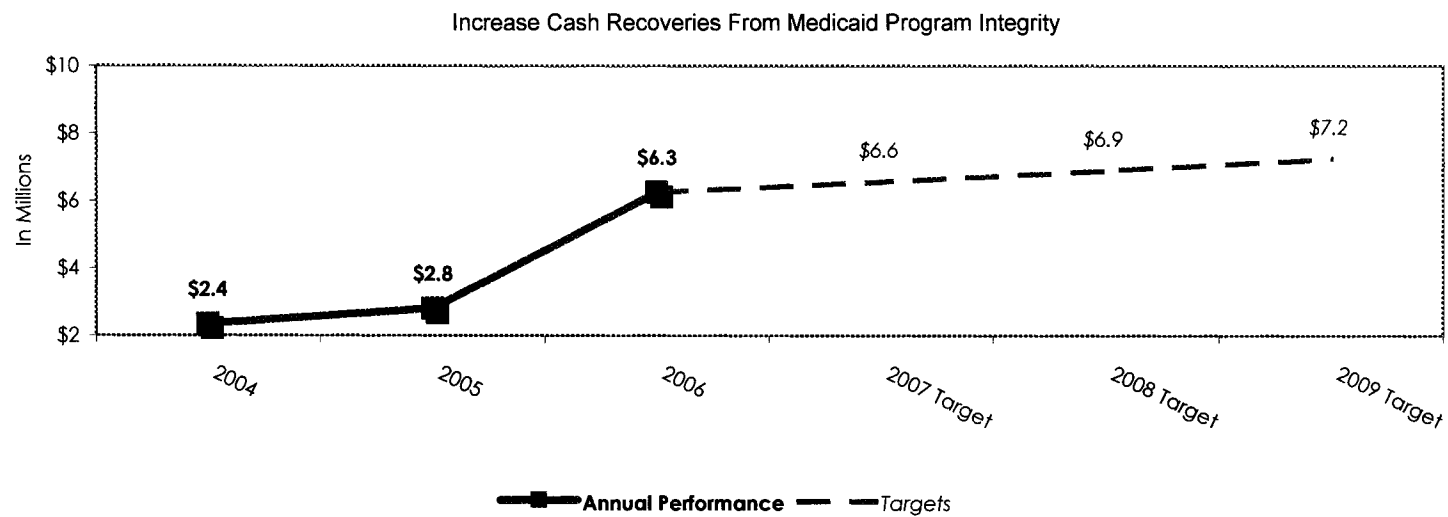
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Travel (140)	250,000		250,000				500,000		
Professional Services (400)	250,000		250,000				500,000		
Total EE	500,000		500,000		0		1,000,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	500,000	0.0	500,000	0.0	0	0.0	1,000,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Travel (140)	0		0				0		
Professional Services (400)	0		0				0		
Total EE	0		0		0		0		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional)

6a. Provide an effectiveness measure.



6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

Home & Community Based Waivers						
Waiver	Individuals Served					
	FY04	FY05	FY06	FY07	FY08	FY09
Aged & Disabled	23,216	22,291	44,731	51,441	59,157	59,157
AIDS	86	82	150	150	150	150
Community Support	475	808	1,034	1,034	1,089	1,117
Independent Living	544	493	600	600	600	600
MOCDD	197	199	216	216	216	216
MRDD Comprehensive	7,443	7,553	7,720	7,575	7,575	7,575
Physical Disabilities	40	47	72	65	75	85

FY04 & FY05 are actuals (FY06 actuals not available yet)

FY06, FY07, FY08, FY09 are projections submitted to CMS. Projections are submitted to CMS 5 years at a time.

Projections are on the high side to allow enough slots for participants.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Detect fraudulent activities by providers and recipients by exploring addition of prepayment edits similar to the National Correct Coding Initiative.
- Participate in the departmental task force being established to examine areas of fraud, waste and abuse.
- Participate in the federal Payment Error Rate Measurement (PERM) project.
- Develop fraud/abuse algorithms.
- Increase access for waiver participants.
- Make satisfactory assurances concerning the protection of waiver participants' health and welfare.
- Develop a process of discovery, remediation and improvement of problems within the Home and Community waivers.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAL SERVICES ADMIN								
Investigation Expense - 1886028								
TRAVEL, IN-STATE	0	0.00	0	0.00	500,000	0.00	0	0.00
PROFESSIONAL SERVICES	0	0.00	0	0.00	500,000	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	1,000,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,000,000	0.00	\$0	0.00
GENERAL REVENUE								
FEDERAL FUNDS								
OTHER FUNDS								

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
HEALTHCARE TECHNOLOGY									
CORE									
PROGRAM-SPECIFIC									
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	4,600,000	0.00	4,600,000	0.00	4,600,000	0.00	
HEALTHCARE TECHNOLOGY FUND	0	0.00	4,950,000	0.00	4,950,000	0.00	4,950,000	0.00	
TOTAL - PD	0	0.00	9,550,000	0.00	9,550,000	0.00	9,550,000	0.00	
TOTAL	0	0.00	9,550,000	0.00	9,550,000	0.00	9,550,000	0.00	
Electronic Med. Histories - 1886029									
PROGRAM-SPECIFIC									
HEALTHCARE TECHNOLOGY FUND	0	0.00	0	0.00	6,800,000	0.00	2,500,000	0.00	
TOTAL - PD	0	0.00	0	0.00	6,800,000	0.00	2,500,000	0.00	
TOTAL	0	0.00	0	0.00	6,800,000	0.00	2,500,000	0.00	
GRAND TOTAL	\$0	0.00	\$9,550,000	0.00	\$16,350,000	0.00	\$12,050,000	0.00	

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Healthcare Technology

Budget Unit: 90518C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD		4,600,000	4,950,000	9,550,000
TRF				
Total		4,600,000	4,950,000	9,550,000
FTE				0.00

<i>Est. Fringe</i>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Healthcare Technology Fund (0170)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD		4,600,000	4,950,000	9,550,000
TRF				
Total		4,600,000	4,950,000	9,550,000
FTE				0.00

<i>Est. Fringe</i>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Healthcare Technology Fund (0170)

2. CORE DESCRIPTION

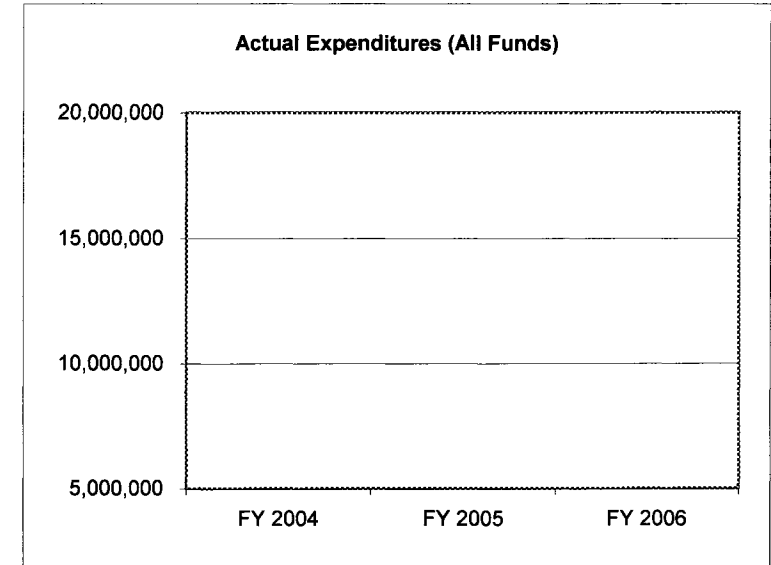
This core request is for the continued funding of health care technology to be used to improve health care delivery efficiency.

3. PROGRAM LISTING (list programs included in this core funding)

Health Care Technology

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	0	0	0	9,550,000
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	0	0	0	N/A
Actual Expenditures (All Funds)	0	0	0	N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A
	(1)	(1)	(1)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) This is a new appropriation.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
HEALTHCARE TECHNOLOGY

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES	PD	0.00	0	4,600,000	4,950,000	9,550,000	
	Total	0.00	0	4,600,000	4,950,000	9,550,000	
DEPARTMENT CORE REQUEST	PD	0.00	0	4,600,000	4,950,000	9,550,000	
	Total	0.00	0	4,600,000	4,950,000	9,550,000	
GOVERNOR'S RECOMMENDED CORE	PD	0.00	0	4,600,000	4,950,000	9,550,000	
	Total	0.00	0	4,600,000	4,950,000	9,550,000	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTHCARE TECHNOLOGY								
CORE								
PROGRAM DISTRIBUTIONS	0	0.00	9,550,000	0.00	9,550,000	0.00	9,550,000	0.00
TOTAL - PD	0	0.00	9,550,000	0.00	9,550,000	0.00	9,550,000	0.00
GRAND TOTAL	\$0	0.00	\$9,550,000	0.00	\$9,550,000	0.00	\$9,550,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$4,600,000	0.00	\$4,600,000	0.00	\$4,600,000	0.00
OTHER FUNDS	\$0	0.00	\$4,950,000	0.00	\$4,950,000	0.00	\$4,950,000	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Health Care Technology

Program is found in the following core budget(s): Health Care Technology

1. What does this program do?

PROGRAM SYNOPSIS: This program uses technology to improve the delivery of care, reduce administrative burdens and reduce waste fraud and abuse.

This program explores new and innovative ideas on ways that technology can improve the delivery of care, reduce administrative burdens and reduce waste, fraud and abuse. The Division of Medical Services (DMS) is committed to identifying Medicaid overpayments and combating fraud, waste and abuse of Medicaid dollars. DMS also recognizes the need to invest in improving the talent and tools used to prevent, identify and deter fraud and abuse in Missouri Medicaid programs. Recent efforts to reduce costs and increase efficiency to improve the Medicaid program include a new fraud and abuse detection system. Medstat Advantage Suite allows staff to design and obtain adhoc reports in order to ferret out possible overpayments due to incorrect claims. This system offers immediate access to claim information on both summary and detail levels that reduce staff time and manual intervention. Efforts need to continue in the development of algorithms and the expansion of the use of technology to combat waste, fraud and abuse.

Funding is used to implement some of the Medicaid Reform Commission recommendations, such as expansion and increased use of technology in healthcare including electronic health records, community health records, personal health records and e-prescribing. Electronic health records (EHRs) are an important tool in healthcare that assists in providing safe, effective healthcare to patients. DMS has implemented a new web-based tool, CyberAccess™. This tool will allow electronic, web-based access to the provider's patient claim information, incorporating paid Medicaid medical and pharmacy claim data into a patient profile. Providers will be able to review patient utilization of services, including medications and services from other providers, diagnoses and procedures, all in a comprehensive listing in chronological order. In addition, CyberAccess includes a feature that allows providers to select a medication for their patient and immediately determine whether it will be reimbursed by Medicaid without limitations such as prior authorization or clinical edit. If such a limitation is in place, the provider may request an override via the electronic tool itself, and eliminate the need for a phone call or fax request.

The web based tool for the program is not an EMR, it is a care and treatment plan which is far less detailed than an EMR would be. It is consistent with the direction of the FQHCs, RHCs, and DHSS chronic care policy. It also represents a platform that could easily interface with a true EMR for those who are ready and will certainly be a step in that direction to help move the standard of practice.

This enhanced prescriber interface will also allow the program's first entry into e-prescribing, i.e. electronic prescribing. After the above process assists in selecting the best and most appropriate product, the prescriber may initiate an e-prescription that will be forwarded to the pharmacy of the patient's choice. As this process matures in prescribers' practices, total e-prescribing will be possible. E-prescribing is becoming a more popular alternative to handwriting a prescription that the patient carries to the pharmacy. Using the technology will allow easier implementation of clinical edits and step therapies by allowing the prescriber to see before finishing with the patient the outcome of the prescription in the Medicaid system. The process will reduce errors and assist in following through with the actual filling of the prescription. DMS has deployed a pilot project that will include electronic prescribing via facsimile to high volume prescribers. This process will assist in reducing errors, following patients' adherence to therapy, and alerting the prescriber of issues while the patient is still in the office. Only approximately 10 percent of prescribers have the capability of e-prescribing today. Most, but not all, pharmacies can accept true e-prescribing. Funding is used to promote implementation and expansion of projects such as these.

DMS is in the process of implementing a Chronic Care Improvement Program (CCIP). The CCIP is basically an enhanced primary care case management program incorporating the tenets of disease management, care coordination and case management to a patient base selected by a risk assessment model. The CCIP goals are to improve health care quality for patients with chronic illness and decrease complications, resulting in reduced cost. The program will increase involvement of a central primary health care provider (e.g., patients will receive extra time and attention), empower patients to perform healthcare self-management, and utilize

existing community resources and health infrastructures through care coordination. Within the System component, the contractor will provide an Internet-based patient Plan of Care (POC) and Information System. Interface with an EMR may be offered optionally by the contractor. The CCIP is not funded through this initiative, however, this fund is critical for the functioning of the program.

These internet tools will assist providers with accessing patient profile information gleaned from paid Medicaid claims and allow their input of patient information upon each office visit. Nationally recognized evidence-based treatment guidelines and patient education materials will be available to providers through this tool. This then would incorporate the support of best practice guidelines, medical evidence to support therapy algorithms and outcome studies to assure the best results for recipients. The strategy is to integrate prevention into the use of technology through electronic medical records to empower individual and community level health decisions and integration/coordination of care by providers.

Funds are used to build a program that emphasizes personal responsibility, health literacy, and creates a structure to guide participants to become better consumers of healthcare. DMS works with its sister agencies, the Department of Health and Senior Services and the Department of Mental Health, as well as the Missouri State Medical Association, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri Nursing Association, the Missouri Hospital Association, the Missouri Peer Review Organization (Primaris), the Missouri Pharmacy Association and others as necessary to coordinate services and reduce duplication of effort among state-based organizations. Additionally several of the groups have already begun initiatives in the provider community to address process and data element issues. Maintaining relationships, using initiatives that already have consensus and enabling collaboration will be key to program success. This will require a considerable amount of communication, but will also result in maximum outreach, consistency for providers, and improved use of various statewide resources.

This fund will also support a collaborative partnership between UMC and DMS for the purposes of improving quality and controlling cost in Missouri's Medicaid program through the analysis of improvement issues using Medicaid claims data and related information. The objective of this initiative will be to jointly develop a program of collaboration that shall support Flexible Issue Teams composed of experts in medicine, health care, health economics, health policy, health communication, data analysis, and data management. These issue teams will conduct research projects, including data analysis and reporting based on guidance from the project leadership team. The leadership team will include members from DMS and UMC. The leadership team will determine project priorities and the on-going agenda of projects including the number of issue teams engaged. The number of issue teams may range from three to six consistent with the complexity of the projects and the availability of budgeted resources. The leadership team will be led by DMS.

Funds include funding for the purpose of providing matching funds for an electronic medical records pilot project in the Metropolitan St. Louis region. Such pilot project shall provide a system which integrates all health care records within a single database and utilizes technology that can be easily shared with other health providers and may be replicated beyond its immediate population. The initial project shall include up to 300,000 individuals and incorporate the patient base of at least 200 physicians. The contractor shall be required to provide at least seven million dollars (\$7,000,000) in matching contributions to the project. Said match may be a combination of cash and in-kind.

Funding supports a community-based care coordinating program that includes in-home visits and/or phone contact by a nurse care manager or electronic monitor. The purpose of such program shall be to ensure that patients are discharged from hospitals to an appropriate level of care and services and that targeted Medicaid beneficiaries with chronic illnesses and high-risk pregnancies receive care in the most cost-effective setting. Areas of implementation shall include, but not be limited to, Greene County.

Projects create data and automation systems that provide critical information about the population served, financial issues, critical management information and health outcomes to support decision-making by factual information.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)
--

TAFP CCS for SCS for HCS for HB1011, Section 11.415

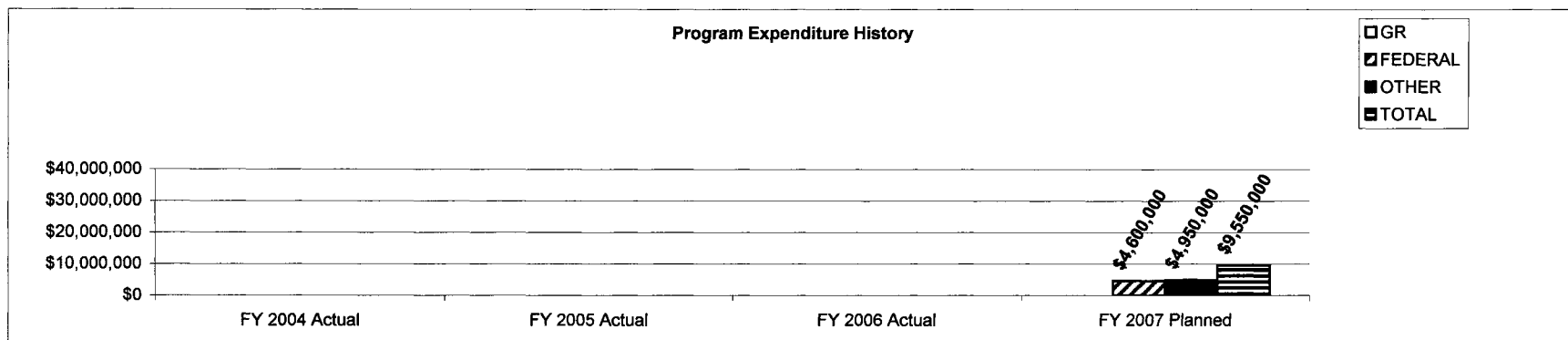
3. Are there federal matching requirements? If yes, please explain.

Expenditures for Health Care Technology that are associated with Medicaid projects earn 50% FFP and require 50% state share. Some Medicaid projects could be eligible for enhanced federal matching of 75% and some projects could even qualify for 90% enhanced federal matching funds. Non-Medicaid related projects do not earn federal match.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



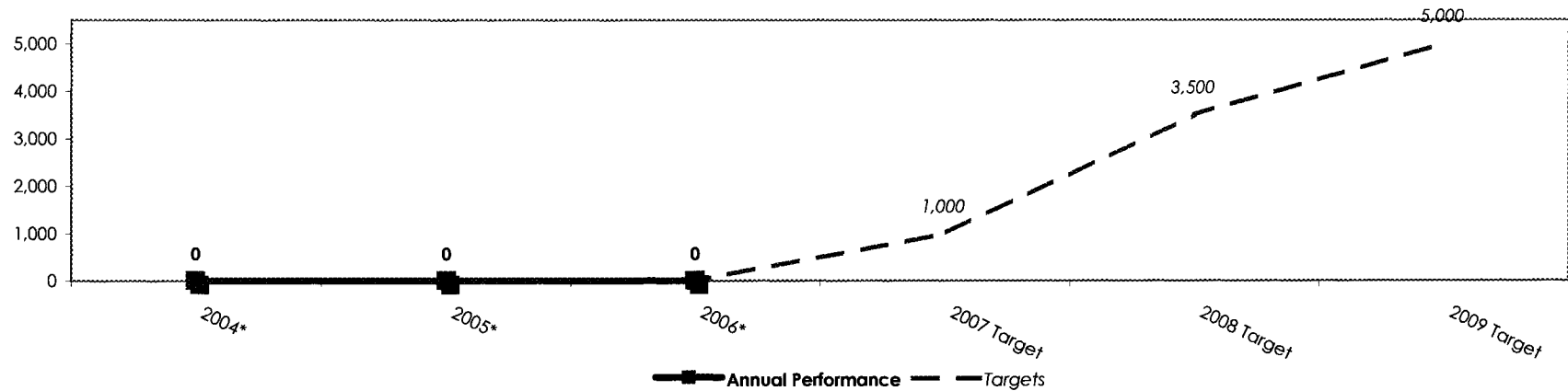
*Health Care Technology Program will begin in Fiscal Year 2007.

6. What are the sources of the "Other" funds?

Health Care Technology Fund (0170)

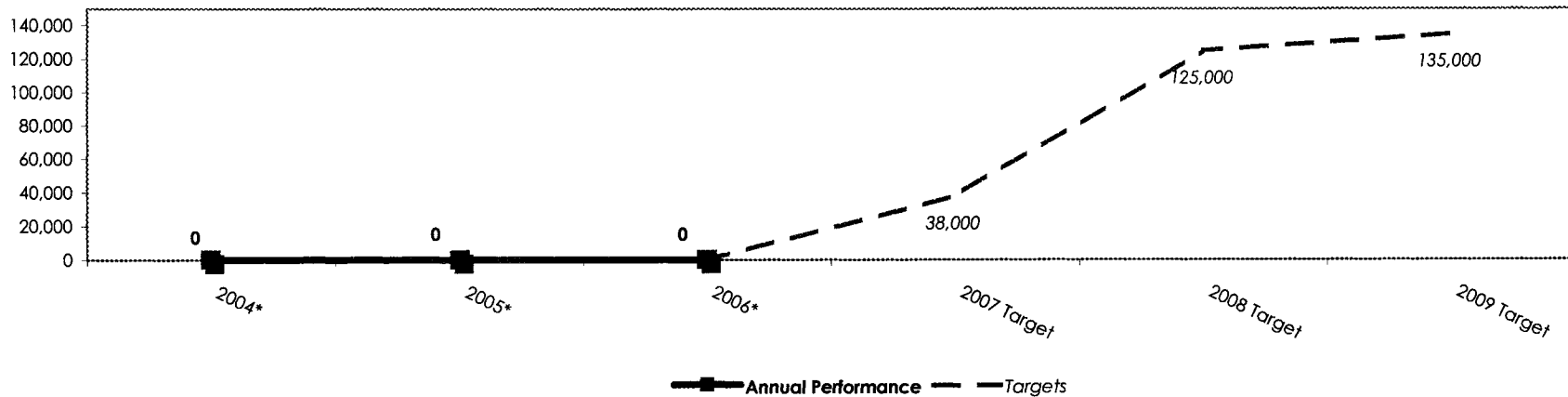
7a. Provide an effectiveness measure.

Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 22**

Department: Social Services
Division: Medical Services
DI Name: Cost-to-Continue Electronic Medical Histories

Budget Unit: 90518C
DI#: 1886029

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			6,800,000	6,800,000
TRF				
Total			6,800,000	6,800,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD			2,500,000	2,500,000
TRF				
Total			2,500,000	2,500,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input checked="" type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to support a statewide patient electronic health record.

Funding would support a statewide relational database that contains integrated medical and pharmacy data in the form of a personal electronic health record. This technology has the capability to include multiple third party payers. The technology would likely be a multidimensional database (data warehouse utilizing cube and cube operations) using the most current SQL server technology enhanced with dot net applications. The data would be state property and access limits would be established and maintained by the State. The vendor would establish a proprietary web based access instrument and support full enhancement capability consistent with the data available, for provider use and patient use. It would provide complete linkage between the pharmacy, patient and medical provider.

State statutory authority is TAFP CCS for SCS for HCS for HB 1011, Section 11.415.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The estimated cost of the patient electronic health record is estimated at \$6.8 million.

No federal funds were included in this decision item for the patient electronic health record at this time. There may be matching funds for the Medicaid portion. DMS will continue to research the availability for these funds.

The instrument would afford the user:

- User friendly point of entry allowing patient to enter their health history and demographics
- A secure and portable data warehouse (as patients move they take their data)
- A set standard for the state for this service
- Availability (subsidized or for modest charge) to employers and other private sector users
- A voluntary integration of paid claims with multiple vendors (i.e. employer sponsored insurance, Medicaid, Missouri Consolidated, United, etc.)
- Confidential Patient Health Information (PHI)
- Reminders for appointments and medication doses
- Specific targeted disease and healthcare information for patient and provider
- Targeted care and treatment guideline information
- Ability for patients to enter self-obtained data
 - Blood pressure
 - Blood glucose
 - Peak flow readings
- An expiring secure emergency access log on for EMT, ER use
- An integration with individual provider/payer systems via a secure download process

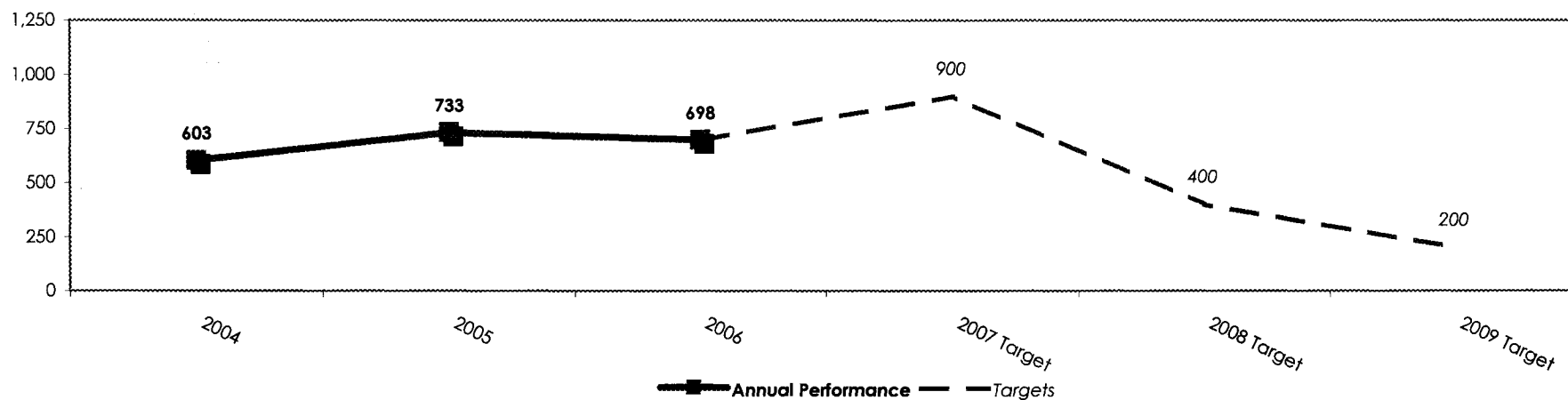
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0	0	0		0		0
Program Distributions					6,800,000		6,800,000		
Total PSD	0		0		6,800,000		6,800,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	6,800,000	0.0	6,800,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions					2,500,000		2,500,000		
Total PSD	0		0		2,500,000		2,500,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	2,500,000	0.0	2,500,000	0.0	0

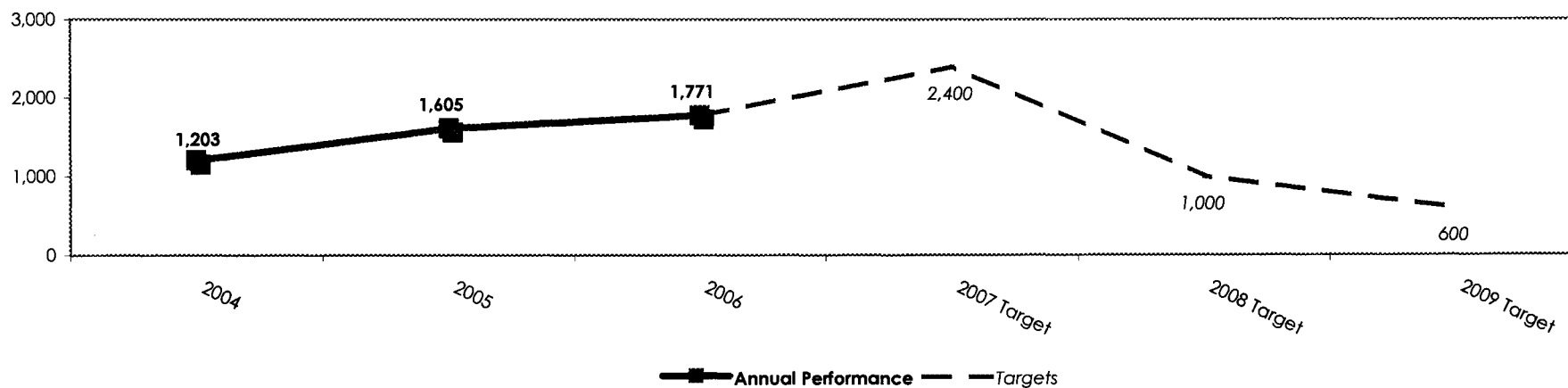
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

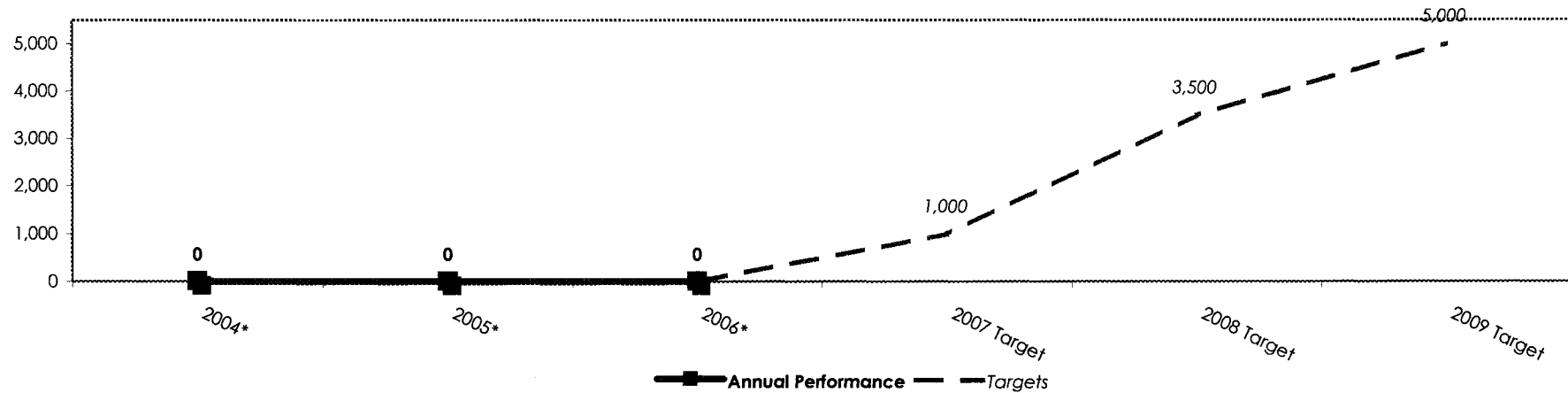
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

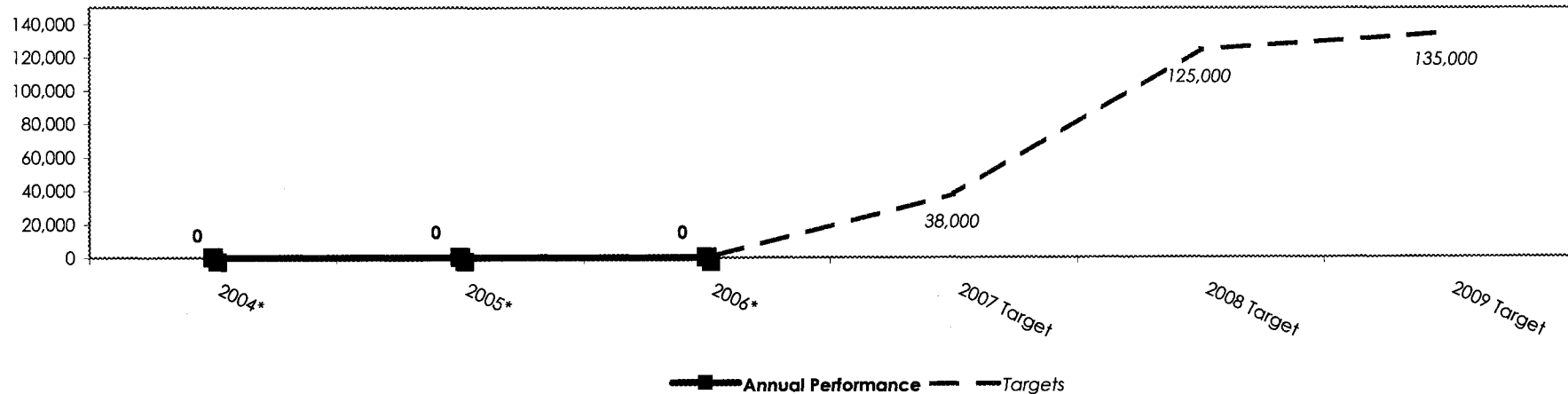


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



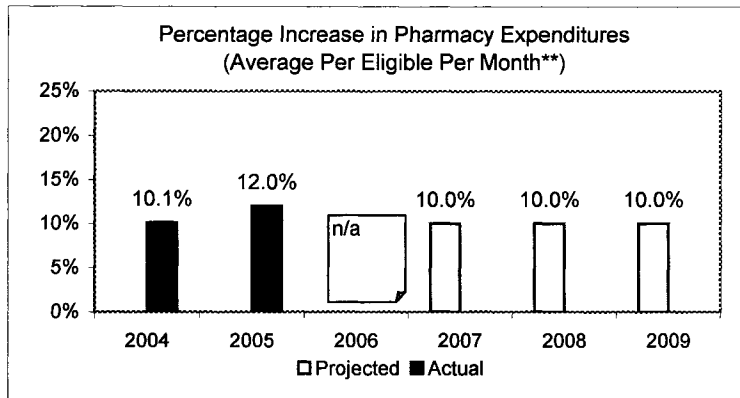
*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Continue statewide identification of recipients with targeted disease states.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioners.
- Dedicated help desk for recipient support.
- Identify providers currently serving the targeted population to invite them to participate in disease management.
- Continue existing cost containment activities.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of the participation and show providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTHCARE TECHNOLOGY								
Electronic Med. Histories - 1886029								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	6,800,000	0.00	2,500,000	0.00
TOTAL - PD	0	0.00	0	0.00	6,800,000	0.00	2,500,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$6,800,000	0.00	\$2,500,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$6,800,000	0.00	\$2,500,000	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY PROGRAM MGMT								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	2,232,089	0.00	2,301,123	0.00	2,301,123	0.00	2,301,123	0.00
DEPT OF SOC SERV FEDERAL & OTH	3,522,788	0.00	3,602,788	0.00	3,602,788	0.00	3,602,788	0.00
THIRD PARTY LIABILITY COLLECT	610,021	0.00	924,911	0.00	924,911	0.00	924,911	0.00
MISSOURI RX PLAN FUND	0	0.00	4,155,894	0.00	4,155,894	0.00	4,155,894	0.00
TOTAL - EE	6,364,898	0.00	10,984,716	0.00	10,984,716	0.00	10,984,716	0.00
PROGRAM-SPECIFIC								
MISSOURI RX PLAN FUND	0	0.00	5,000	0.00	5,000	0.00	5,000	0.00
TOTAL - PD	0	0.00	5,000	0.00	5,000	0.00	5,000	0.00
TOTAL	6,364,898	0.00	10,989,716	0.00	10,989,716	0.00	10,989,716	0.00
Pharmacy/Clinical Model - 1886030								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	0	0.00	0	0.00	850,000	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	0	0.00	850,000	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	1,700,000	0.00	0	0.00
TOTAL	0	0.00	0	0.00	1,700,000	0.00	0	0.00
GRAND TOTAL	\$6,364,898	0.00	\$10,989,716	0.00	\$12,689,716	0.00	\$10,989,716	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Pharmacy Program Management

Budget Unit: 90516C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	2,301,123	3,602,788	5,080,805	10,984,716
PSD			5,000	5,000
TRF				
Total	2,301,123	3,602,788	5,085,805	10,989,716

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Third Party Liability Collections (TPL) (0120)
MO Rx Plan Fund (0779)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	2,301,123	3,602,788	5,080,805	10,984,716
PSD			5,000	5,000
TRF				
Total	2,301,123	3,602,788	5,085,805	10,989,716

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Third Party Liability Collections (TPL) (0120)
MO Rx Plan Fund (0779)

2. CORE DESCRIPTION

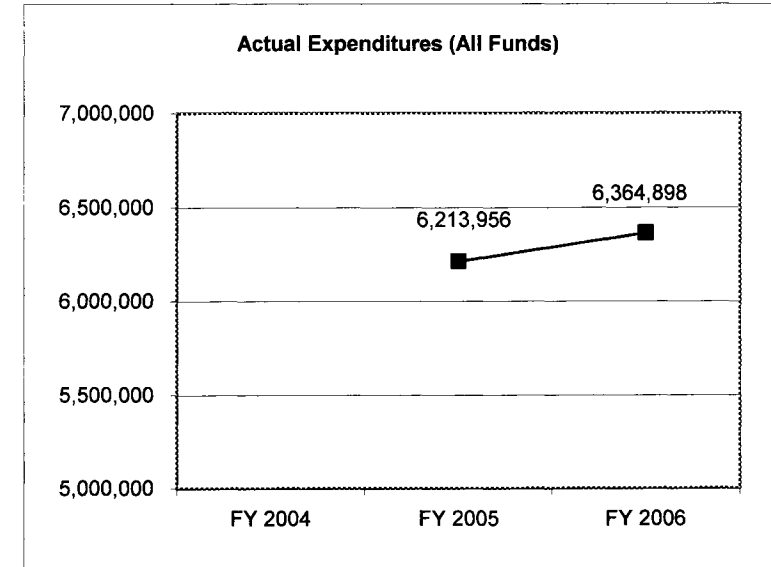
This core request is for the continued operation of the Missouri Medicaid Pharmacy Enhancement Program and the Missouri Rx program. The Division of Medical Services seeks to aid recipients and providers in their efforts to access the Medicaid program by utilizing contractor resources effectively.

3. PROGRAM LISTING (list programs included in this core funding)

Missouri Medicaid Pharmacy Enhancement Program
Missouri Rx Program

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)		6,828,822	6,828,822	10,989,716
Less Reverted (All Funds)		(119,034)	(69,034)	N/A
Budget Authority (All Funds)	0	6,709,788	6,759,788	N/A
Actual Expenditures (All Funds)		6,213,956	6,364,898	N/A
Unexpended (All Funds)	0	495,832	394,890	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	133,442	80,000	N/A
Other	0	362,390	314,890	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Pharmacy Program Management expenditures were part of Medicaid Administration expenditures in FY 2004.

(2) Agency reserve of \$268,790 - \$50,000 in Federal and \$218,790 in TPL funds.

(3) Agency reserve of \$350,166 - \$80,000 in Federal and \$270,166 in TPL funds.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

PHARMACY PROGRAM MGMT

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	EE	0.00	2,301,123	3,602,788	5,080,805	10,984,716	
	PD	0.00	0	0	5,000	5,000	
	Total	0.00	2,301,123	3,602,788	5,085,805	10,989,716	
DEPARTMENT CORE REQUEST							
	EE	0.00	2,301,123	3,602,788	5,080,805	10,984,716	
	PD	0.00	0	0	5,000	5,000	
	Total	0.00	2,301,123	3,602,788	5,085,805	10,989,716	
GOVERNOR'S RECOMMENDED CORE							
	EE	0.00	2,301,123	3,602,788	5,080,805	10,984,716	
	PD	0.00	0	0	5,000	5,000	
	Total	0.00	2,301,123	3,602,788	5,085,805	10,989,716	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY PROGRAM MGMT								
CORE								
SUPPLIES	439	0.00	0	0.00	0	0.00	0	0.00
PROFESSIONAL SERVICES	6,331,600	0.00	10,984,716	0.00	10,984,716	0.00	10,984,716	0.00
M&R SERVICES	28,021	0.00	0	0.00	0	0.00	0	0.00
OFFICE EQUIPMENT	4,838	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	6,364,898	0.00	10,984,716	0.00	10,984,716	0.00	10,984,716	0.00
PROGRAM DISTRIBUTIONS	0	0.00	5,000	0.00	5,000	0.00	5,000	0.00
TOTAL - PD	0	0.00	5,000	0.00	5,000	0.00	5,000	0.00
GRAND TOTAL	\$6,364,898	0.00	\$10,989,716	0.00	\$10,989,716	0.00	\$10,989,716	0.00
GENERAL REVENUE	\$2,232,089	0.00	\$2,301,123	0.00	\$2,301,123	0.00	\$2,301,123	0.00
FEDERAL FUNDS	\$3,522,788	0.00	\$3,602,788	0.00	\$3,602,788	0.00	\$3,602,788	0.00
OTHER FUNDS	\$610,021	0.00	\$5,085,805	0.00	\$5,085,805	0.00	\$5,085,805	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Pharmacy Program Management

Program is found in the following core budget(s): Pharmacy Program Management

1. What does this program do?

PROGRAM SYNOPSIS: The funding in the Pharmacy Program Management section supports the Pharmacy Enhancement program contractor costs.

With a pharmacy budget of over \$1 billion in FY07, it is necessary to have resources to manage the program. The administrative rate is less than 0.6% of the total Medicaid pharmacy budget. Through the Pharmacy Enhancement Program, the Division is able to maintain current cost containment initiatives and implement new cost containment initiatives. Major initiatives include:

- Help Desk Staffing
- Quarterly Updates to the Missouri Maximum Allowable Cost (MACs)
- Maintenance and Updates to Fiscal and Clinical Edits
- Prospective and Retrospective Drug Use Review (DUR)
- Routine/Adhoc Drug Information Research
- Enrollment and Administration of Disease Management
- Enrollment and Administration of Case Management
- Preferred Drug List (PDL) and Supplemental Rebates

These initiatives, along with other cost containment activities, have resulted in an increase in the pharmacy cost that is significantly below the national trend over the past two years. Due to the current fiscal climate, administrative resources are scrutinized very closely. However, it is critical to look at the rate of return, instead of the actual dollars expended. Based on previous analysis, the rate of return on these pharmacy cost containment initiatives range from \$28:1 to \$99:1.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.201; Federal law: Social Security Act Section 1902(a)(4); Federal Regulations: 42 CFR, Part 432

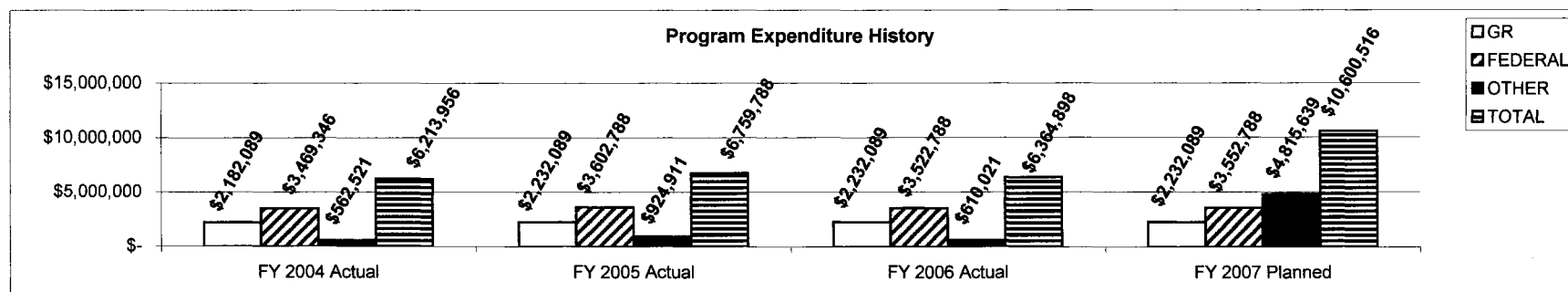
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.

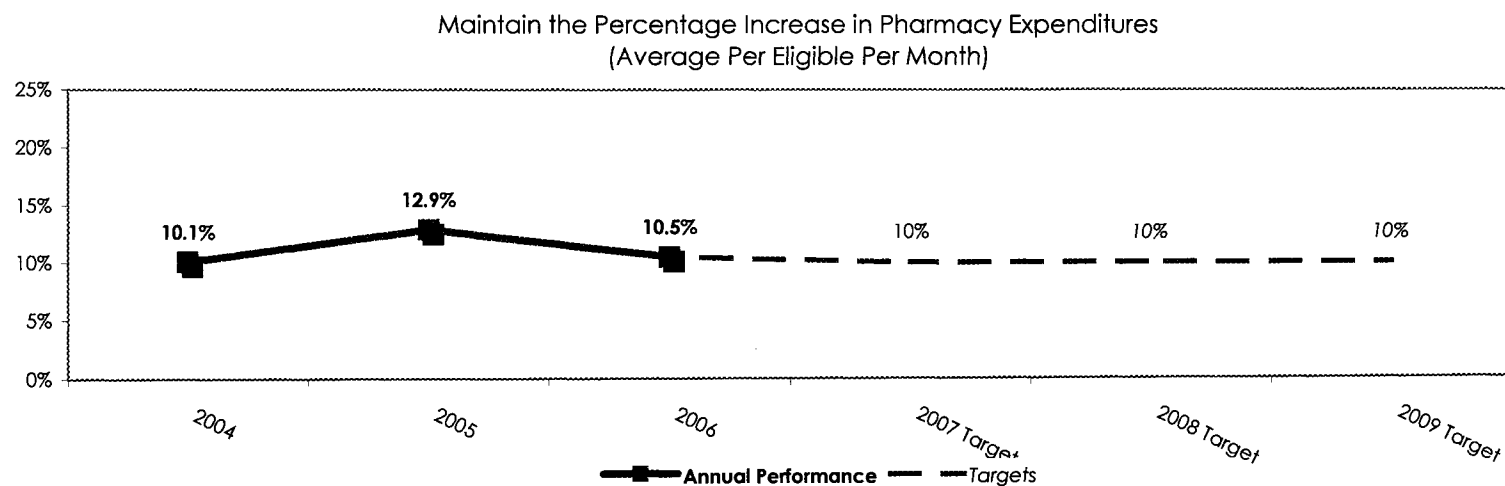
5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

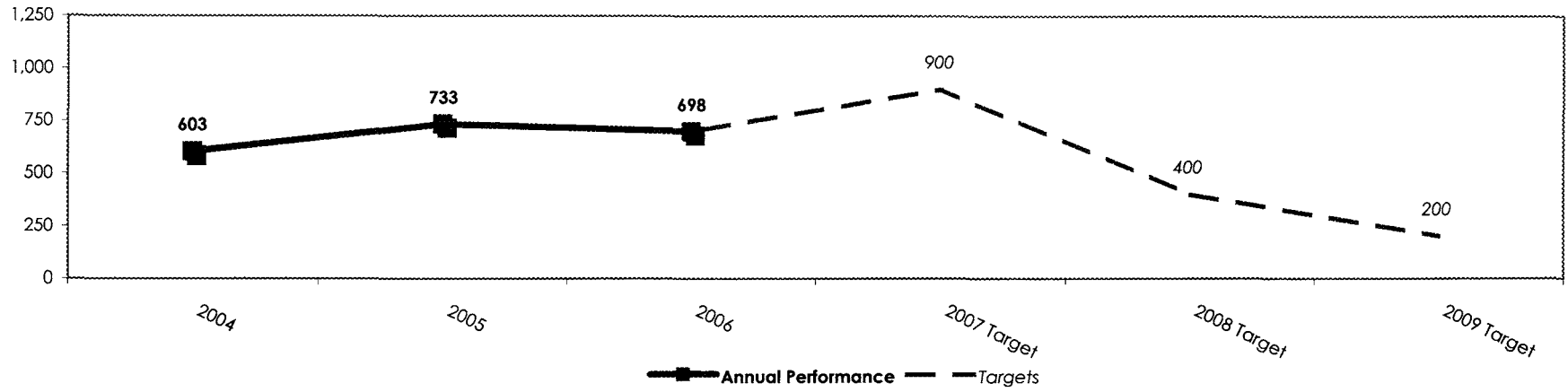
Third Party Liability Collections Fund (0120) - FY2004-FY2007
 Missouri Rx Plan Fund (0779) - FY2007

7a. Provide an effectiveness measure.

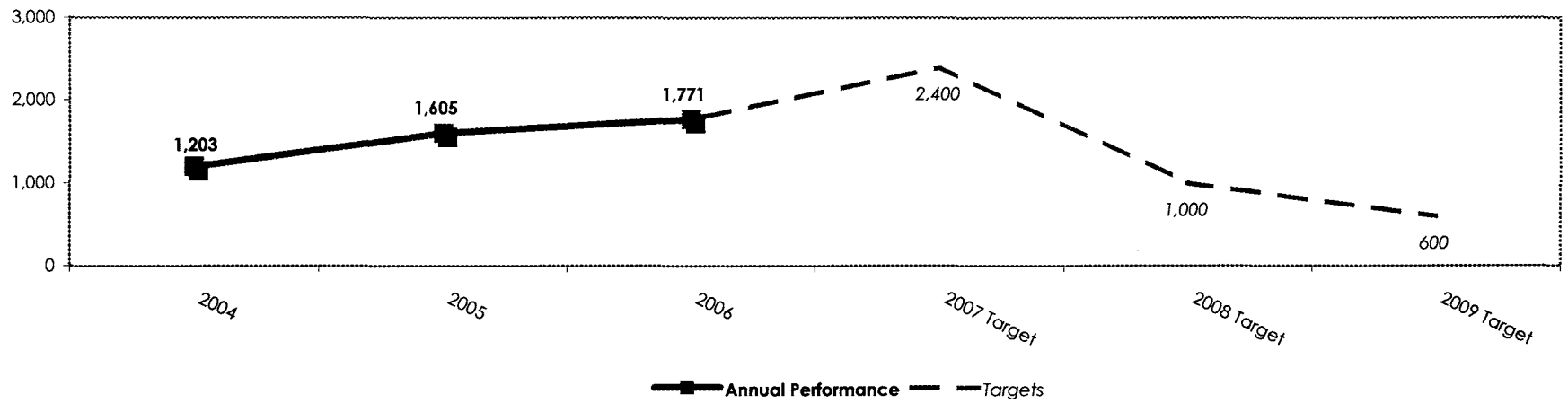


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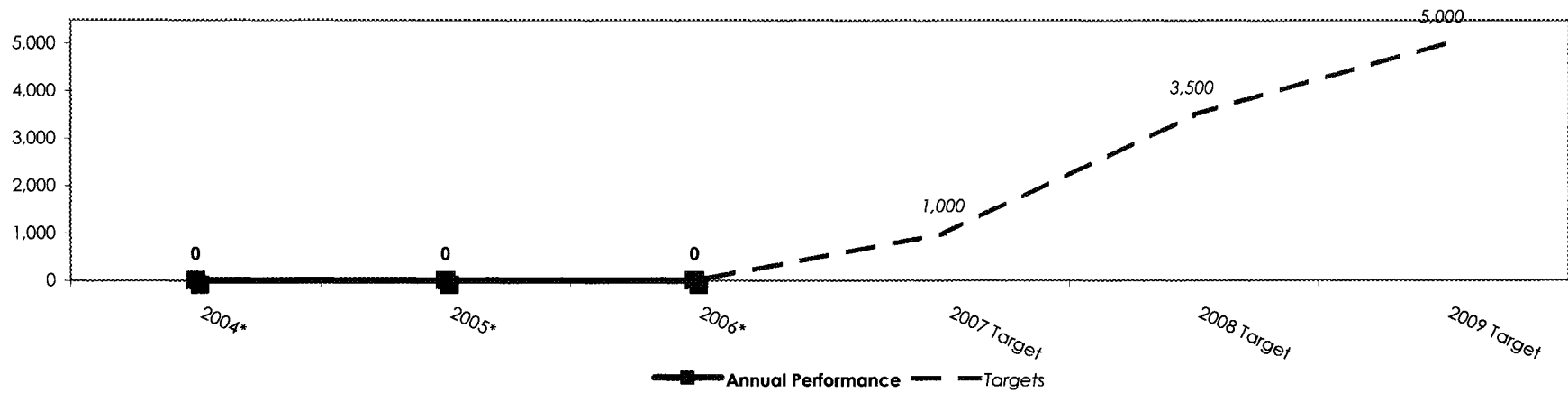
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

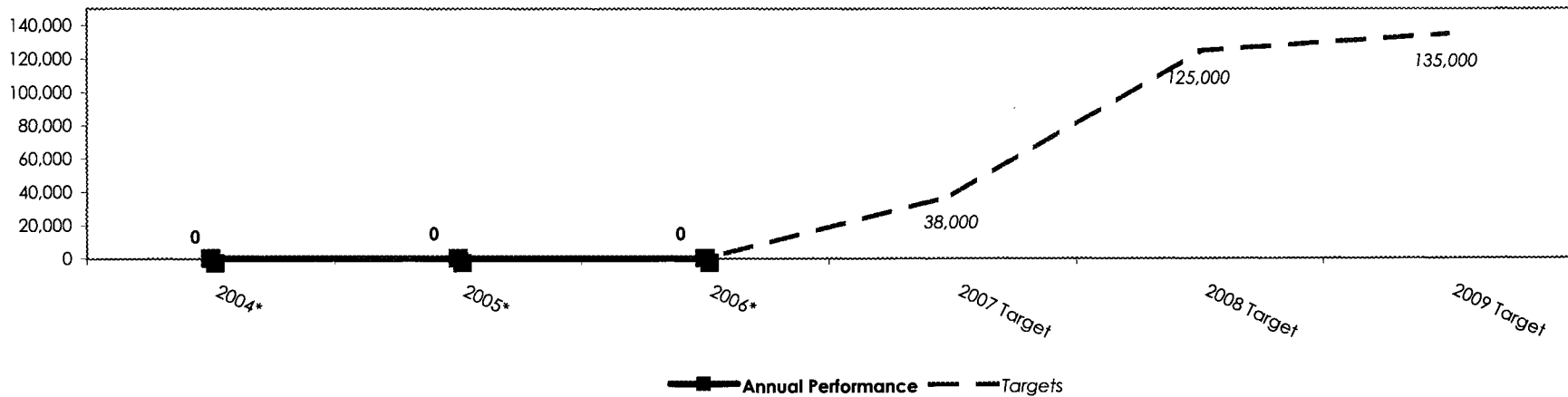


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Number of Pharmacy Claims		
SFY	Actual	Projected
2004	17.1 mil	16.5 mil
2005	19.1 mil	18.8 mil
2006	15.3 mil	16.2 mil*
2007		10.4 mil
2008		11.4 mil
2009		12.4 mil

*Reduction in FY06 due to the Medicare Modernization Act (MMA)

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 43**

**Department: Social Services
Division: Medical Services
DI Name: Pharmacy/Clinical Model**

**Budget Unit: 90516C
DI#: 1886030**

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE	850,000	850,000		1,700,000
PSD				
TRF				
Total	850,000	850,000		1,700,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to support pharmacy and clinical services technology and technology related initiatives.

The funding is being requested to support the change in the operation of DMS to a business model. Funding requested for, but not limited to, electronic medical/health records, CyberAccess, Care Connection, Direct Rx Pro, Medication Therapy Management (MTM), data exchanges and Chronic Care Improvement Program (CCIP) support.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

The estimated cost for the ongoing support for the pharmacy and clinical services and for the change in the operation of DMS to a business mode is estimated at \$1.7 million.

There will be matching federal funds of 50% for the ongoing support for the pharmacy and clinical services development.

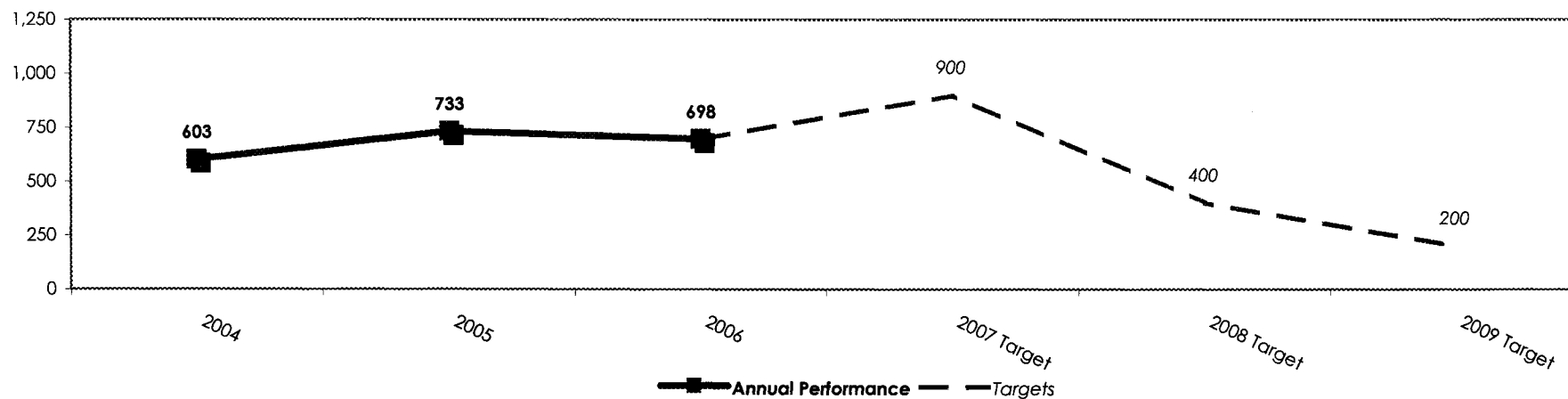
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
 Professional Services (400)	 850,000		 850,000				 1,700,000		
Total EE	850,000		850,000		0		1,700,000		0
 Total PSD	 0		 0		 0		 0		 0
Transfers									
Total TRF	0		0		0		0		0
 Grand Total	 850,000	 0.0	 850,000	 0.0	 0	 0.0	 1,700,000	 0.0	 0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)									
Total EE	0		0		0		0		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

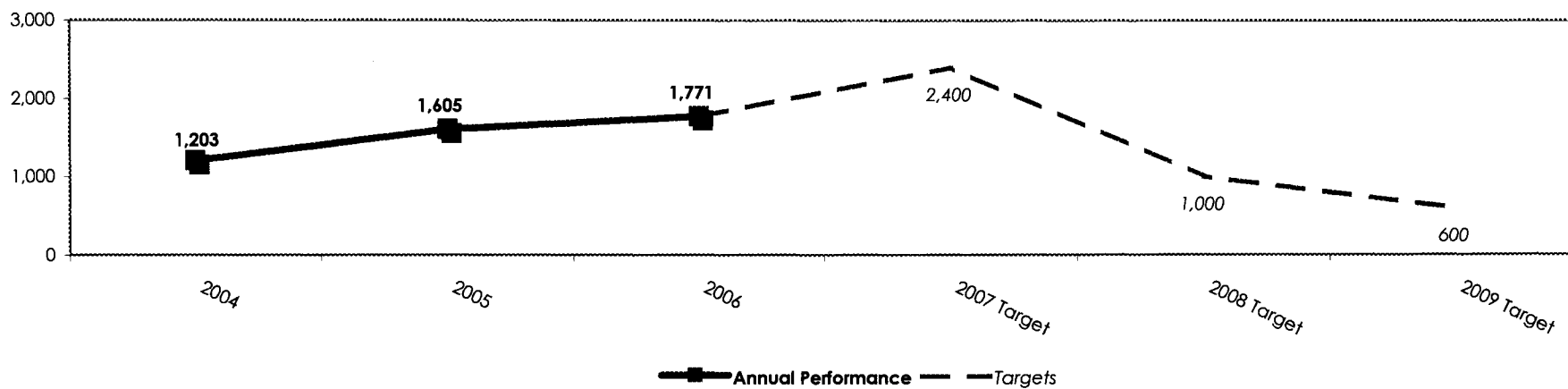
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

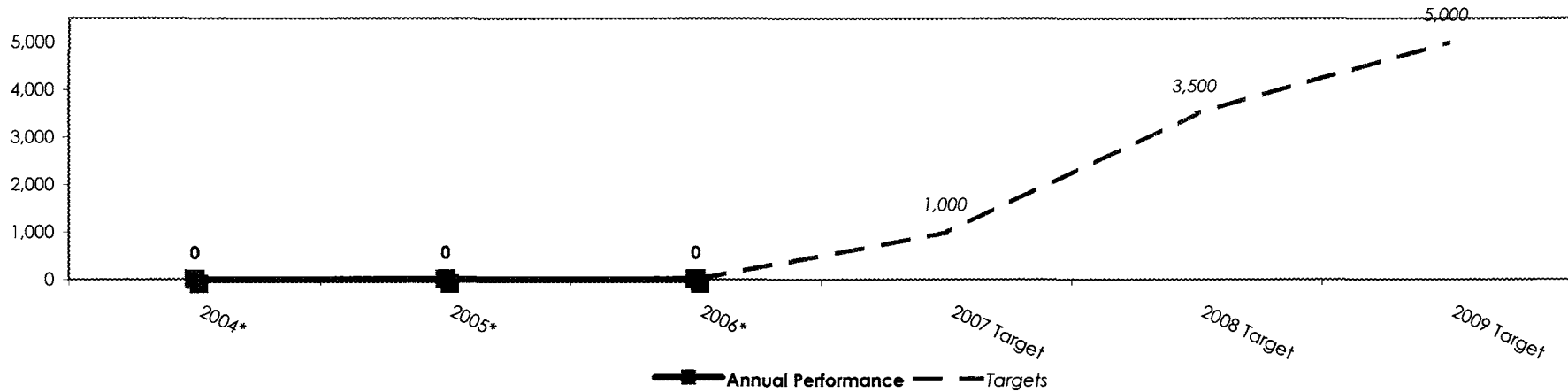
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

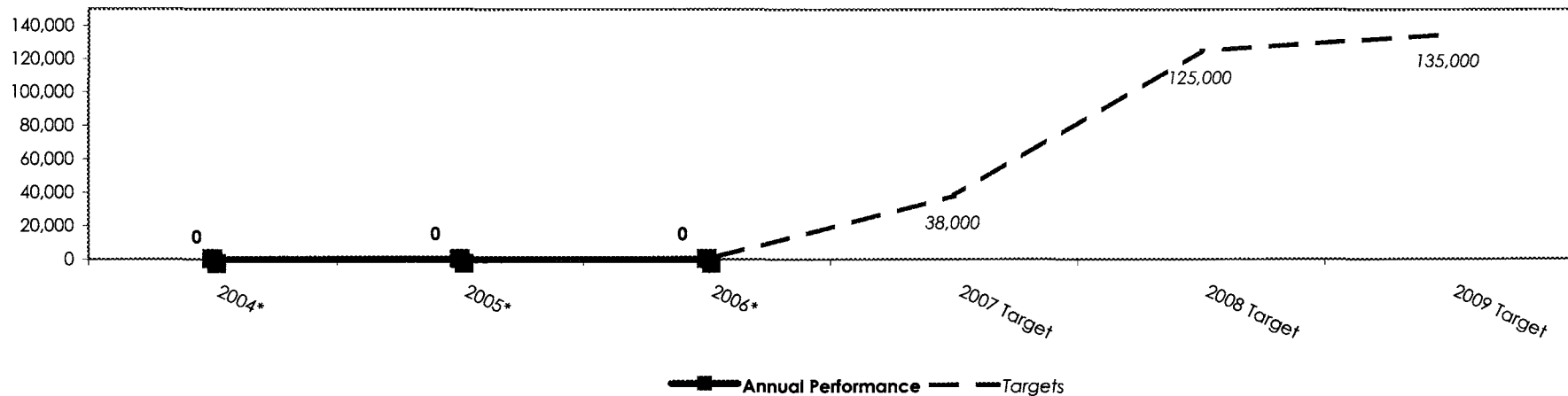


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



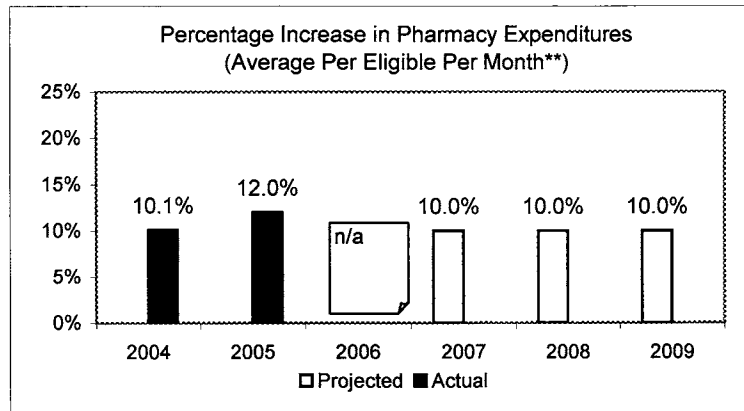
*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Continue statewide identification of recipients with targeted disease states.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioners.
- Dedicated help desk for recipient support.
- Identify providers currently serving the targeted population to invite them to participate in disease management.
- Continue existing cost containment activities.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of the participation and show providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY PROGRAM MGMT								
Pharmacy/Clinical Model - 1886030								
PROFESSIONAL SERVICES	0	0.00	0	0.00	1,700,000	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	1,700,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,700,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$850,000	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$850,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
WOMEN & MINORITY OUTREACH								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	546,125	0.00	546,125	0.00	546,125	0.00	546,125	0.00
DEPT OF SOC SERV FEDERAL & OTH	568,625	0.00	568,625	0.00	568,625	0.00	568,625	0.00
TOTAL - EE	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00
TOTAL	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00
GRAND TOTAL	\$1,114,750	0.00	\$1,114,750	0.00	\$1,114,750	0.00	\$1,114,750	0.00

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CORE DECISION ITEM

Department: Social Services
 Division: Medical Services
 Appropriation: Women & Minority Health Care Outreach

Budget Unit: 90513C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	546,125	568,625		1,114,750
PSD				
TRF				
Total	546,125	568,625		1,114,750
FTE				0.00

<i>Est. Fringe</i>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	546,125	568,625		1,114,750
PSD				
TRF				
Total	546,125	568,625		1,114,750
FTE				0.00

<i>Est. Fringe</i>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

2. CORE DESCRIPTION

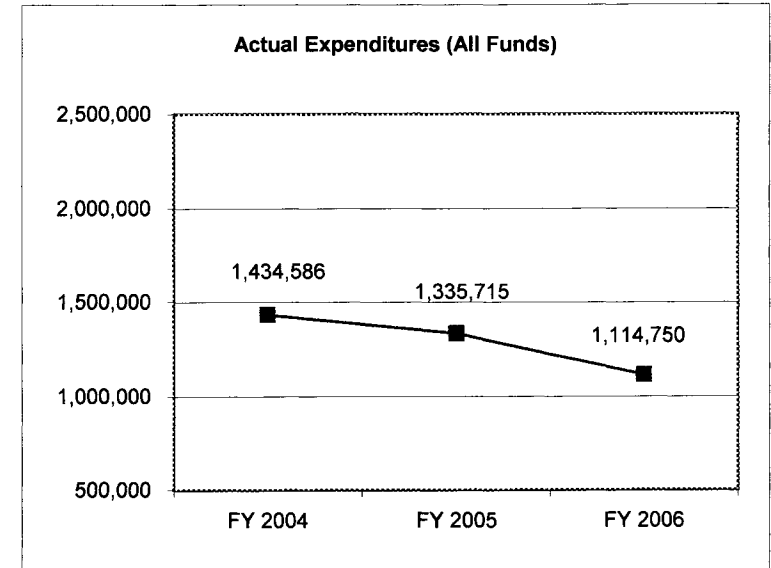
This core request is for the continued funding of the Women and Minority Health Care Outreach programs. These programs provide client outreach and education about the Medicaid program and reduce disparities in healthcare access for women and minority populations.

3. PROGRAM LISTING (list programs included in this core funding)

Women and Minority Health Care Outreach Program

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	1,500,000	1,477,500	1,114,750	1,114,750
Less Reverted (All Funds)	(22,500)	(21,825)		N/A
Budget Authority (All Funds)	1,477,500	1,455,675	1,114,750	N/A
Actual Expenditures (All Funds)	1,434,586	1,335,715	1,114,750	N/A
Unexpended (All Funds)	42,914	119,960	0	N/A
Unexpended, by Fund:				
General Revenue	21,728	57,141	0	N/A
Federal	21,186	62,819	0	N/A
Other	0	0	0	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**WOMEN & MINORITY OUTREACH**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES	EE	0.00	546,125	568,625	0	1,114,750	
	Total	0.00	546,125	568,625	0	1,114,750	
DEPARTMENT CORE REQUEST	EE	0.00	546,125	568,625	0	1,114,750	
	Total	0.00	546,125	568,625	0	1,114,750	
GOVERNOR'S RECOMMENDED CORE	EE	0.00	546,125	568,625	0	1,114,750	
	Total	0.00	546,125	568,625	0	1,114,750	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
WOMEN & MINORITY OUTREACH								
CORE								
PROFESSIONAL SERVICES	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00
TOTAL - EE	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00	1,114,750	0.00
GRAND TOTAL	\$1,114,750	0.00	\$1,114,750	0.00	\$1,114,750	0.00	\$1,114,750	0.00
GENERAL REVENUE	\$546,125	0.00	\$546,125	0.00	\$546,125	0.00	\$546,125	0.00
FEDERAL FUNDS	\$568,625	0.00	\$568,625	0.00	\$568,625	0.00	\$568,625	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Women and Minority Health Care Outreach

Program is found in the following core budget(s): Women and Minority Health Care Outreach

1. What does this program do?

PROGRAM SYNOPSIS: Provides client outreach and education about the Medicaid program with a goal to reduce disparities in health care access for women and minority populations.

The health of Missouri's citizens is critical to the well-being of the state. Without proper health care, Missouri citizens will be less productive and more costly to the state. The purpose of the Missouri Medicaid program is to finance, monitor and assure the health coverage of traditionally vulnerable populations. The funding in this appropriation provides outreach services in St. Louis, Columbia, Springfield, the Bootheel, and the Kansas City Region targeted at African American men and women at risk of diabetes, cardiovascular disease, HIV/AIDS, sexually transmitted diseases (STDs), and other life-threatening health conditions. The outreach programs also provide client outreach and education about the Medicaid program.

The Department of Social Services has contracted with the Missouri Primary Care Association to act as a fiscal intermediary for the distribution of the Minority and Women's Health Outreach funding, assuring accurate and timely payments to the subcontractors and to act as a central data collection point for evaluation of program impact and outcomes. The Missouri Primary Care Association is recognized as Missouri's single primary care association by the federal Health Resource Service Administration. The goals of the nation's Primary Care Associations are to partner in the development, maintenance and improvement of access to health care services, and to reduce disparities in health status between majority and minority populations.

This program was initiated in the fall of 1999 with five Federally-Qualified Health Centers (FQHCs) and has now expanded to ten FQHCs in the St Louis and Kansas City regions and the Bootheel, plus a consultant subcontractor. The outreach program builds on the strengths of ten FQHCs that are trusted, accessible sources of care for high-risk African American populations, and the existence of natural leaders, often women, in African American neighborhoods to provide outreach and education in their neighborhoods to encourage routine screenings for diabetes and cardiovascular disease and testing for HIV/AIDS and STDs. In the Bootheel area, the outreach program builds on the strengths of a FQHC and county hospital, using the Care-A-Van to reach at-risk persons in the largely rural area. Existing health promotion coalitions in the area, including the Bootheel's Heart Health Coalitions and the Missouri Health Alliance will also be used in outreach efforts. As part of the outreach program, workers identify eligible recipients and help them enroll in the Medicaid program.

The current contractor is Missouri Primary Care Association. The contractor is paid for allowable costs related to establishing and implementing outreach programs not to exceed the appropriation cap.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.201; Federal law: Social Security Act Section 1903(a); Federal Regulations: 42 CFR, Part 433.15

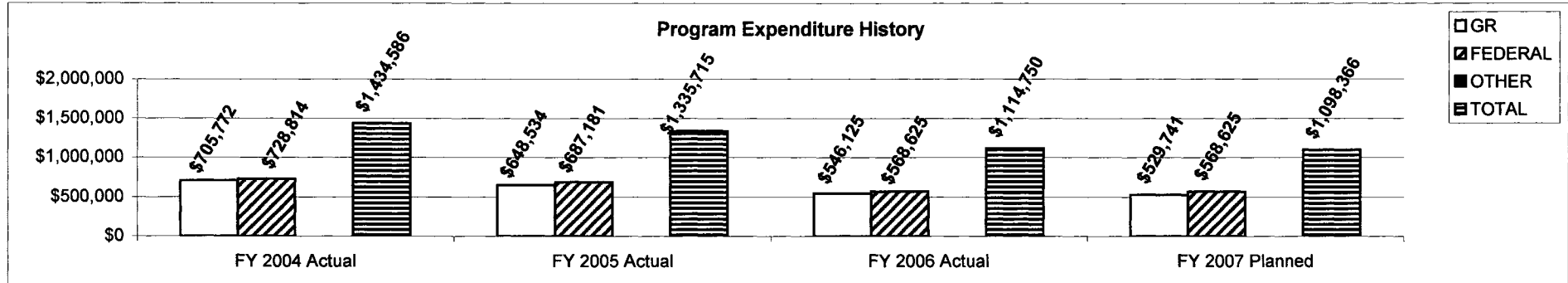
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Prenatal Care Users Who Delivered During the Year		
SFY	Actual	Projected
2004	2,332	2,469
2005	2,867	2,667
2006	3,329	3,182
2007		3,596
2008		4,064
2009		

Number of Normal Births		
SFY	Actual	Projected
2004	2,100	2,133
2005	2,809	2,261
2006	2,926	3,118
2007		3,523
2008		3,981
2009		

Eligibles:

Services are directed toward low-income women and minorities who are uninsured or eligible for Medicaid.

7d. Provide a customer satisfaction measure, if available.

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAID REVENUE MAX UNIT								
CORE								
PERSONAL SERVICES								
DEPT OF SOC SERV FEDERAL & OTH	63,089	1.51	86,736	2.00	86,736	2.00	86,736	2.00
FEDERAL REIMBURSEMENT ALLOWANCE	63,089	1.51	86,736	2.00	86,736	2.00	86,736	2.00
TOTAL - PS	126,178	3.02	173,472	4.00	173,472	4.00	173,472	4.00
EXPENSE & EQUIPMENT								
DEPT OF SOC SERV FEDERAL & OTH	1,741	0.00	8,114	0.00	8,114	0.00	8,114	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	0	0.00	8,114	0.00	8,114	0.00	8,114	0.00
TOTAL - EE	1,741	0.00	16,228	0.00	16,228	0.00	16,228	0.00
TOTAL	127,919	3.02	189,700	4.00	189,700	4.00	189,700	4.00
GENERAL STRUCTURE ADJUSTMENT - 0000012								
PERSONAL SERVICES								
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	0	0.00	0	0.00	2,603	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	0	0.00	0	0.00	0	0.00	2,603	0.00
TOTAL - PS	0	0.00	0	0.00	0	0.00	5,206	0.00
TOTAL	0	0.00	0	0.00	0	0.00	5,206	0.00
GRAND TOTAL	\$127,919	3.02	\$189,700	4.00	\$189,700	4.00	\$194,906	4.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Medicaid Revenue Maximization Unit

Budget Unit: 90514C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS		86,736	86,736	173,472
EE		8,114	8,114	16,228
PSD				
TRF				
Total		94,850	94,850	189,700
FTE		2.00	2.00	4.00

Est. Fringe	0	45,831	45,831	91,663
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS		86,736	86,736	173,472
EE		8,114	8,114	16,228
PSD				
TRF				
Total		94,850	94,850	189,700
FTE		2.00	2.00	4.00

Est. Fringe	0	45,831	45,831	91,663
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

2. CORE DESCRIPTION

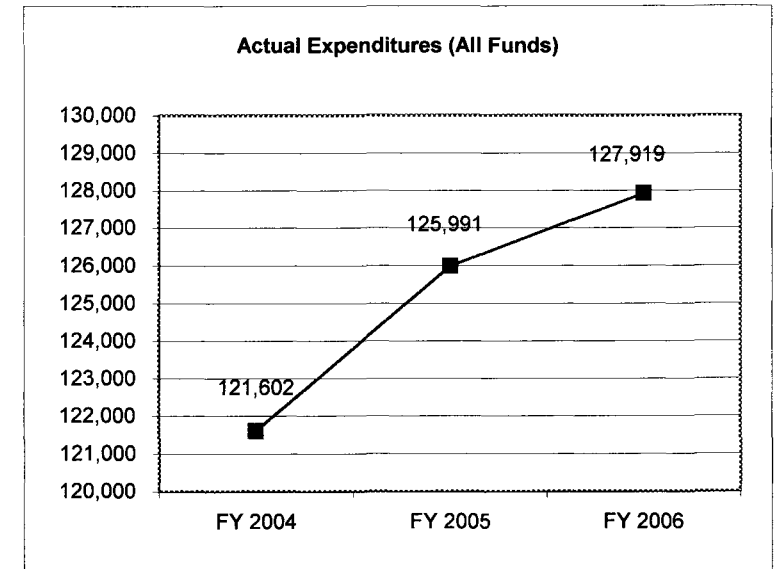
This core request is for the continued operation of the revenue maximization unit made up of four staff.

3. PROGRAM LISTING (list programs included in this core funding)

Medicaid Revenue Maximization

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	178,572	183,372	183,028	189,700
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	178,572	183,372	183,028	N/A
Actual Expenditures (All Funds)	121,602	125,991	127,919	N/A
Unexpended (All Funds)	56,970	57,381	55,109	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	27,209	27,820	26,684	N/A
Other	29,761	29,561	28,425	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**MEDICAID REVENUE MAX UNIT**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	PS	4.00	0	86,736	86,736	173,472	
	EE	0.00	0	8,114	8,114	16,228	
	Total	4.00	0	94,850	94,850	189,700	
DEPARTMENT CORE REQUEST							
	PS	4.00	0	86,736	86,736	173,472	
	EE	0.00	0	8,114	8,114	16,228	
	Total	4.00	0	94,850	94,850	189,700	
GOVERNOR'S RECOMMENDED CORE							
	PS	4.00	0	86,736	86,736	173,472	
	EE	0.00	0	8,114	8,114	16,228	
	Total	4.00	0	94,850	94,850	189,700	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAID REVENUE MAX UNIT								
CORE								
OFFICE SUPPORT ASST (CLERICAL)	0	0.00	24,128	1.00	24,128	1.00	24,128	1.00
AUDITOR II	0	0.00	0	0.00	42,848	1.00	42,848	1.00
SENIOR AUDITOR	17,870	0.46	0	0.00	42,848	1.00	42,848	1.00
AUDITOR III	49,272	1.00	63,648	1.00	63,648	1.00	63,648	1.00
ACCOUNTANT II	59,036	1.56	85,696	2.00	0	0.00	0	0.00
TOTAL - PS	126,178	3.02	173,472	4.00	173,472	4.00	173,472	4.00
TRAVEL, IN-STATE	0	0.00	1,182	0.00	1,182	0.00	1,182	0.00
SUPPLIES	0	0.00	6,000	0.00	6,000	0.00	6,000	0.00
COMMUNICATION SERV & SUPP	0	0.00	2,172	0.00	2,172	0.00	2,172	0.00
M&R SERVICES	1,741	0.00	4,818	0.00	4,818	0.00	4,818	0.00
OFFICE EQUIPMENT	0	0.00	2,056	0.00	2,056	0.00	2,056	0.00
TOTAL - EE	1,741	0.00	16,228	0.00	16,228	0.00	16,228	0.00
GRAND TOTAL	\$127,919	3.02	\$189,700	4.00	\$189,700	4.00	\$189,700	4.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$64,830	1.51	\$94,850	2.00	\$94,850	2.00	\$94,850	2.00
OTHER FUNDS	\$63,089	1.51	\$94,850	2.00	\$94,850	2.00	\$94,850	2.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Revenue Maximization Unit

Program is found in the following core budget(s): Revenue Maximization Unit

1. What does this program do?

PROGRAM SYNOPSIS: These staff identify ways to earn additional federal funds and research ways to avoid costs.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.201, Federal law: Social Security Act Section 1902(a)(4), Federal regulations: 42 CFR Part 432.

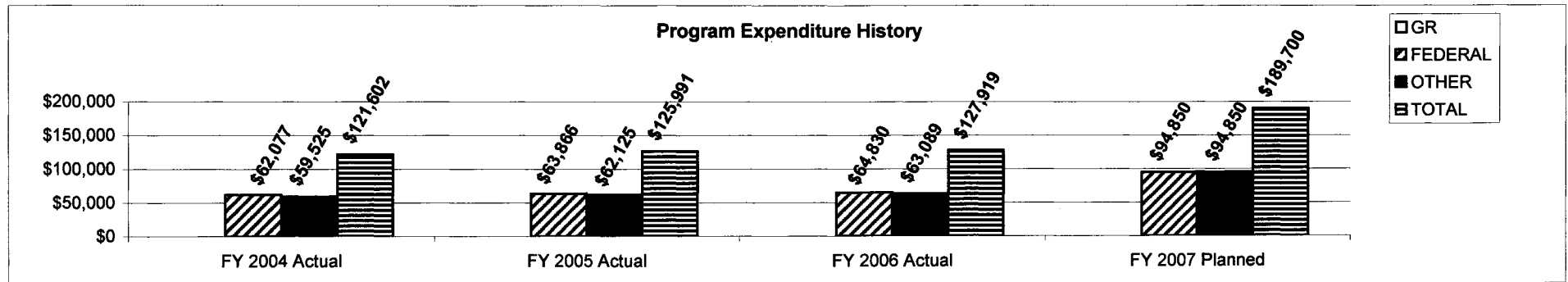
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

Federal Reimbursement Allowance Fund (0142)

7a. Provide an effectiveness measure.

FRA as a Funding Source in the Various Appropriations	
Managed Care	\$109,065,009
Hospital	\$150,057,328
HCA-1115 Waiver Adults	\$167,756
CHIP	\$7,719,204
Revenue Max Admin	\$94,850

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
TPL CONTRACTS									
CORE									
EXPENSE & EQUIPMENT									
DEPT OF SOC SERV FEDERAL & OTH	958,176	0.00	3,000,000	0.00	3,000,000	0.00	3,000,000	0.00	
THIRD PARTY LIABILITY COLLECT	957,404	0.00	3,000,000	0.00	3,000,000	0.00	3,000,000	0.00	
TOTAL - EE	1,915,580	0.00	6,000,000	0.00	6,000,000	0.00	6,000,000	0.00	
TOTAL	1,915,580	0.00	6,000,000	0.00	6,000,000	0.00	6,000,000	0.00	
GRAND TOTAL	\$1,915,580	0.00	\$6,000,000	0.00	\$6,000,000	0.00	\$6,000,000	0.00	

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Third Party Liability (TPL) Contracts

Budget Unit: 90515C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE		3,000,000	3,000,000	6,000,000
PSD				
TRF				
Total		3,000,000	3,000,000	6,000,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Third Party Liability Collections Fund (TPL) (0120)

Notes: An "E" is requested for \$3,000,000 Other Funds and \$3,000,000 Federal Funds

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE		3,000,000	3,000,000	6,000,000
PSD				
TRF				
Total		3,000,000	3,000,000	6,000,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Third Party Liability Collections Fund (TPL) (0120)

Notes: An "E" is requested for \$3,000,000 Other Funds and \$3,000,000 Federal Funds

2. CORE DESCRIPTION

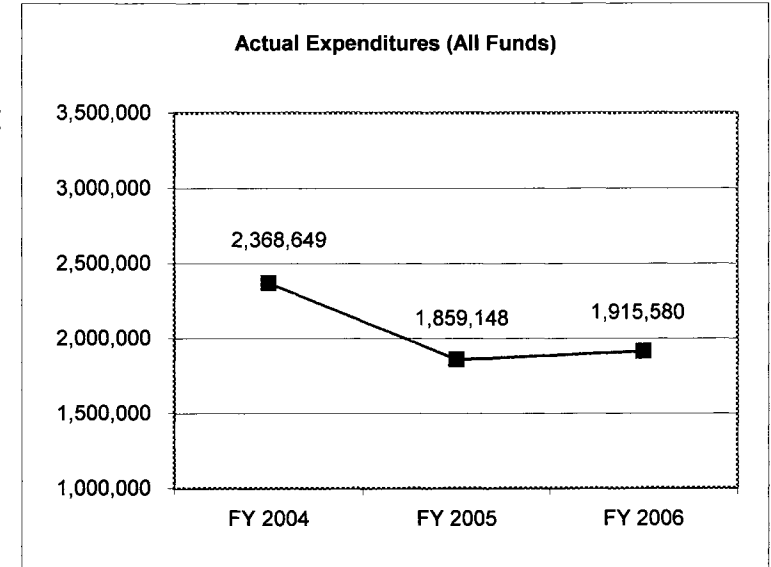
This core request is for the continued funding of contracted third party liability (TPL) recovery activities. TPL functions are performed by agency staff in the TPL Unit and by a contractor. This core appropriation is Expense and Equipment funding and is the source of payments to the contractor who works with the agency on TPL recovery activities.

3. PROGRAM LISTING (list programs included in this core funding)

Third Party Liability Contracts

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	2,372,000	6,000,000	6,000,000	6,000,000 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	2,372,000	6,000,000	6,000,000	N/A
Actual Expenditures (All Funds)	2,368,649	1,859,148	1,915,580	N/A
Unexpended (All Funds)	3,351	4,140,852	4,084,420	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	18,596	2,070,123	2,041,824	N/A
Other	18,596	2,070,729	2,042,596	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriations for FY 2004, FY2006 and FY2007. FY 2005 is NOT an estimated appropriation.

(1) "E" increase in FY2004 - \$186,000 TPL and \$186,000 FF.

(2) Contractor recoveries were lower than expected.

(3) Agency reserve of \$3,000,000 - \$1,500,000 Federal and \$1,500,000 TPL funds - to align appropriation authority to contractor payments.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**TPL CONTRACTS**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	EE	0.00	0	3,000,000	3,000,000	6,000,000	
	Total	0.00	0	3,000,000	3,000,000	6,000,000	
DEPARTMENT CORE REQUEST							
	EE	0.00	0	3,000,000	3,000,000	6,000,000	
	Total	0.00	0	3,000,000	3,000,000	6,000,000	
GOVERNOR'S RECOMMENDED CORE							
	EE	0.00	0	3,000,000	3,000,000	6,000,000	
	Total	0.00	0	3,000,000	3,000,000	6,000,000	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
TPL CONTRACTS								
CORE								
PROFESSIONAL SERVICES	1,915,580	0.00	6,000,000	0.00	6,000,000	0.00	6,000,000	0.00
TOTAL - EE	1,915,580	0.00	6,000,000	0.00	6,000,000	0.00	6,000,000	0.00
GRAND TOTAL	\$1,915,580	0.00	\$6,000,000	0.00	\$6,000,000	0.00	\$6,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$958,176	0.00	\$3,000,000	0.00	\$3,000,000	0.00	\$3,000,000	0.00
OTHER FUNDS	\$957,404	0.00	\$3,000,000	0.00	\$3,000,000	0.00	\$3,000,000	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Third Party Liability (TPL) Contracts

Program is found in the following core budget(s): Third Party Liability (TPL) Contracts

1. What does this program do?

PROGRAM SYNOPSIS: Provides payments for contracted TPL recovery activities. By identifying other insurance carriers, Medicaid is able to cost avoid or recover costs already incurred.

The Third Party Liability (TPL) program is responsible for cost recovery and cost avoidance of Medicaid expenditures. The Medicaid program seeks recovery from third party sources when liability at the time of service had not yet been determined, when the third party source was not known at the time of Medicaid payment, and for services that are federally mandated to be paid and then pursued. TPL functions are performed by agency staff in the TPL Unit and by a contractor. The TPL Contracts appropriation allows for payments to the contractor who works with the agency on TPL recovery activities. The contractor is paid for its services through a portion of cash recoveries. The third-party recovery program accounted for more than \$163.2 million in savings for the state Medicaid program in FY 06 by cost-avoiding claims and TPL recoveries. Managed Health Care Plans in the MC+ Managed Care program are responsible for the collection of TPL from commercial health insurance for Medicaid recipients in their plan.

The contractor has historically been successful in areas of recovery that the state is unable to pursue due to staff and computer system limitations. These recovery areas include Medicare Crossover Repricing, Medicare Maximization, Provider Credit Balance Audits, Family Planning FFP, and Health Insurance Recovery. Once the retroactive cash recovery benefit is exhausted, these recovery areas are converted to cost avoidance mechanisms and transferred to the state MMIS claims processing system. The advantage of the contractor is their use of automation to increase TPL recoveries. Information stored in the data base tables includes recipient eligibility, insurance carrier, billing addresses, insurance coverage, and other reference information that is necessary for automated billing. The TPL Unit and the contractor will share responsibility for maintaining and updating the data tables, as well as conducting the manual operations that continue to be a part of the recovery program.

Even though some responsibilities are shared, the TPL Unit and the contractor each perform specific cost saving and recovery activities. The TPL Unit concentrates on asserting liens on settlements of trauma-related incidents (which include personal injury, product liability, wrongful death, malpractice, workers' compensation, and traffic accidents). The TPL Unit also files claims for recovery of Medicaid expenditures in estate cases, on the personal funds accounts of deceased nursing home residents, and on any excess funds from irrevocable burial plans. For cost avoidance, the TPL Unit operates the Health Insurance Premium Payment (HIPP) Program and maintains the TPL data base where recipient insurance information is stored. The contractor focuses on bulk billings to insurance carriers and other third parties and data matches to identify potential third parties. The following table itemizes the activities performed by the contractor as compared to those performed by the TPL Unit staff, and is followed by descriptions of the primary TPL programs.

TASKS PERFORMED BY STATE TPL STAFF

- ✓ Liens, updates and follow-up on Trauma cases
- ✓ Identify and follow-up on all Estate cases
- ✓ Identify, file and follow-up on TEFRA liens
- ✓ Identify and follow-up on Personal Funds cases
- ✓ Recover any excess funds from irrevocable burial plans
- ✓ Operate HIPP program

- ✓ Post recoveries to Accounts Receivable systems
- ✓ Maintain state TPL databases
- ✓ Verification of leads through MMIS contract
- ✓ Contract Oversight

TASKS PERFORMED BY THE CONTRACTOR

- ✓ Health insurance billing and follow-up
- ✓ Data matches and associated billing (CHAMPUS, MCHCP, other insurance carriers)
- ✓ Provide TPL information for state files
- ✓ Post Accounts Receivable data to state A/R system
- ✓ Maintain insurance billing files

The current contractor is Health Management Systems. The contractor is paid for its services on a contingency basis through a portion of cash recoveries. The contractor is working on several special one-time projects for recoveries approved by the division.

HIPP Program - The objective of the Health Insurance Premium Payment Program (HIPP) is to identify and maintain insurance policies for Medicaid recipients to maximize Medicaid monies by shifting medical costs to private insurers and exhausting all third party resources before utilizing Medicaid. On average, each insurance policy paid by the HIPP program saves \$378 annually.

Trauma Settlement Recovery - The objective is to identify potentially liable third parties and to assert liens on litigation settlements to insure maximum recovery of Medicaid expenditures. Each identification is researched to determine if pursuit is cost effective or even possible.

Personal Funds Recovery - The objective of this program is to identify Personal Funds Account Balances in nursing facilities where the Medicaid recipient had died and to assert a lien on those funds to recover Medicaid expenditures made on behalf of those recipients. A cooperative effort is made with the Department of Health and Senior Services to obtain reports of deceased residents in nursing facilities.

Burial Plans Recovery - The objective of this program is to recover Medicaid expenditures from any excess funds from irrevocable burial plans. Burial lots and irrevocable burial contracts are exempt from consideration in determining Medicaid eligibility (Section 208.010, RSMo). The law also provides that if there are excess funds from irrevocable burial plans, the state should recover the excess up to the amount of public assistance benefits provided to the recipient.

Estate Recovery - In this program, expenditures are recovered through identification and filing of claims on estates of deceased Medicaid recipients. Data matches are coordinated with the Department of Health's Vital Statistics, Family Support county offices' staff and cooperation of other public and private groups. Once cases are established, staff verifies expenditure documentation and assemble data for evidence. The TPL staff appear in court to testify on behalf of the state and explain Medicaid policies and procedures.

TEFRA Liens - The Tax Equity and Fiscal Responsibility Act of 1982 authorizes the Medicaid program to file a lien as a claim against the real property of certain Medicaid recipients. The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of a Medicaid recipient.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State: RSMo. 208.153, 208.215; Federal law: Social Security Act, Section 1902, 1903, 1906, 1912, 1917; Federal regulation: 42 CFR 433 Subpart D

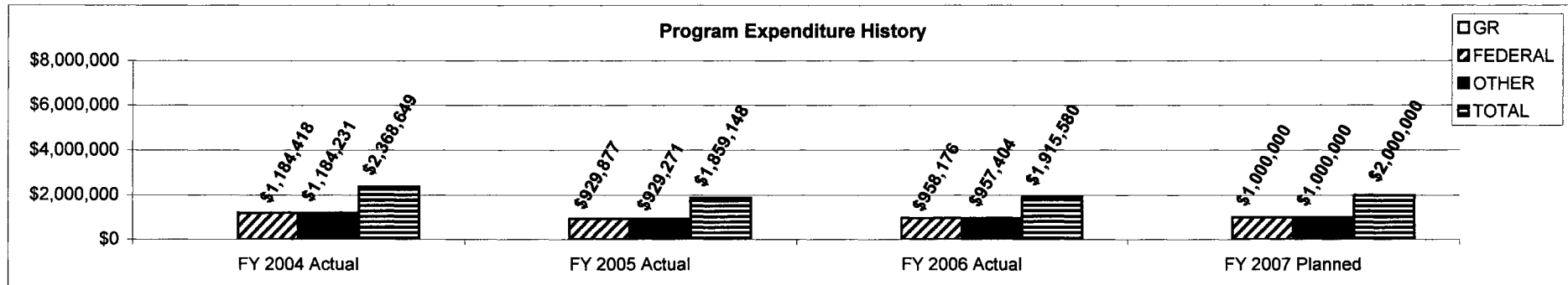
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

Yes, if cost effective. In order to not pursue a TPL claim, the agency must obtain a waiver from CMS by proving that a cost recovery effort is not cost effective.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

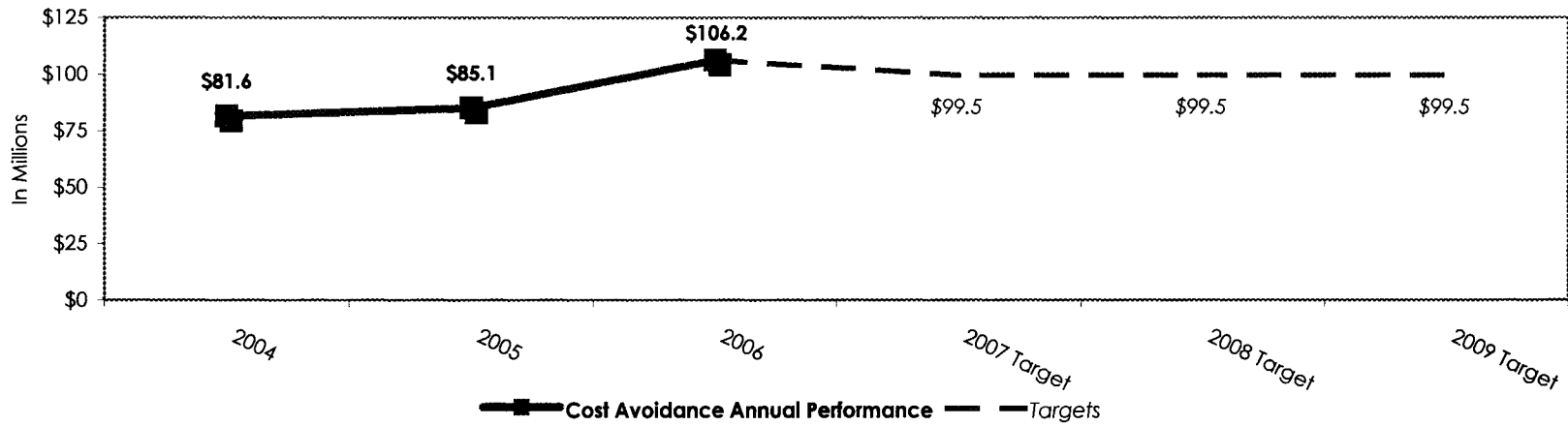
Third Party Liability Collections Fund (0120)

7a. Provide an effectiveness measure.

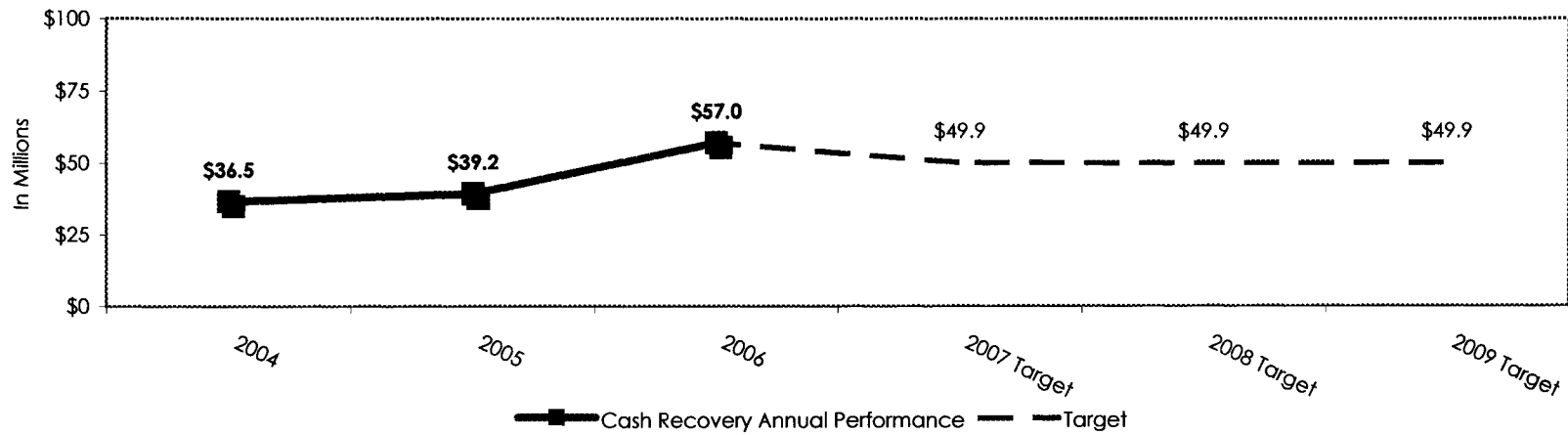
Third Party Liability Recoveries as a Percentage of Total Fee for Service Expenditures		
SFY	Actual	Projected
2004	2.9%	
2005	2.7%	
2006	2.8%	3.0%
2007		3.0%
2008		3.0%
2009		3.0%

7b. Provide an efficiency measure.

Maintain Cost Avoidance From Medicaid Third Party Liability



Increase Cash Recoveries From Medicaid Third Party Liability



Cash Recoveries by Contractor		
SFY	Actual	Projected
2004	\$17.3 mil	\$11.0 mil
2005	\$13.7 mil	\$46.0 mil
2006	\$26.0 mil	\$25.0 mil
2007		\$21.9 mil
2008		\$21.9 mil
2009		\$21.9 mil

Cash Recoveries by DMS Staff		
SFY	Actual	Projected
2004	\$19.2 mil	\$12.5 mil
2005	\$24.6 mil	\$21.0 mil
2006	\$31.0 mil	\$23.6 mil
2007		\$28.0 mil
2008		\$28.0 mil
2009		\$28.0 mil

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
INFORMATION SYSTEMS									
CORE									
EXPENSE & EQUIPMENT									
GENERAL REVENUE	5,395,629	0.00	5,697,417	0.00	5,697,417	0.00	5,697,417	0.00	
DEPT OF SOC SERV FEDERAL & OTH	18,542,731	0.00	19,851,039	0.00	19,851,039	0.00	19,851,039	0.00	
TOTAL - EE	23,938,360	0.00	25,548,456	0.00	25,548,456	0.00	25,548,456	0.00	
TOTAL	23,938,360	0.00	25,548,456	0.00	25,548,456	0.00	25,548,456	0.00	
MMIS Modernization - 1886031									
EXPENSE & EQUIPMENT									
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	0	0.00	34,940,000	0.00	34,940,000	0.00	
HEALTHCARE TECHNOLOGY FUND	0	0.00	0	0.00	5,660,000	0.00	5,660,000	0.00	
TOTAL - EE	0	0.00	0	0.00	40,600,000	0.00	40,600,000	0.00	
TOTAL	0	0.00	0	0.00	40,600,000	0.00	40,600,000	0.00	
GRAND TOTAL	\$23,938,360	0.00	\$25,548,456	0.00	\$66,148,456	0.00	\$66,148,456	0.00	

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Information Systems

Budget Unit: 90522C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE	5,697,417	19,851,039		25,548,456
PSD				
TRF				
Total	5,697,417	19,851,039		25,548,456

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE	5,697,417	19,851,039		25,548,456
PSD				
TRF				
Total	5,697,417	19,851,039		25,548,456

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. CORE DESCRIPTION

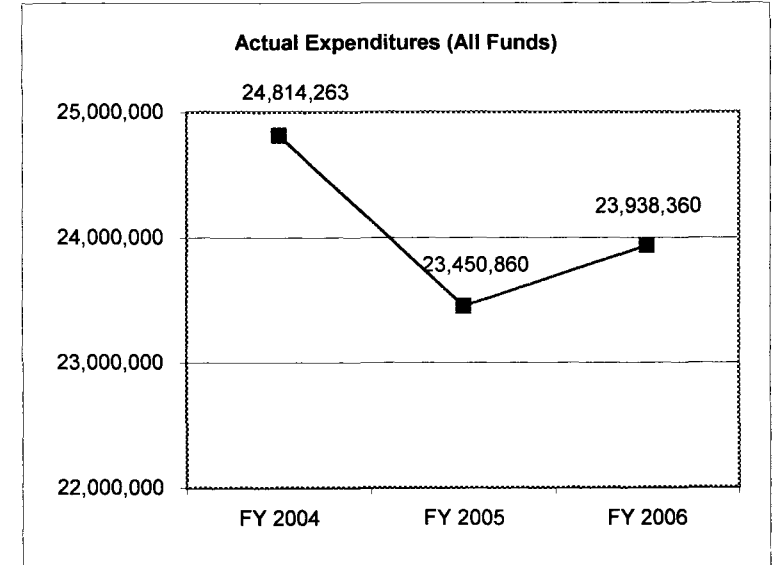
This core request is for the continued funding of Information Systems (IS), which is a component of the Division's total administrative costs. Information Systems is comprised of two program areas, MMIS (Medicaid Management Information System) and the Medicaid Fraud and Abuse Detection system (FADS).

3. PROGRAM LISTING (list programs included in this core funding)

Information Systems

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	25,037,732	23,632,812	24,104,462	25,548,456
Less Reverted (All Funds)	(196,920)	(181,952)	(166,102)	N/A
Budget Authority (All Funds)	24,840,812	23,450,860	23,938,360	N/A
Actual Expenditures (All Funds)	24,814,263	23,450,860	23,938,360	N/A
Unexpended (All Funds)	26,549	0	0	N/A
Unexpended, by Fund:				
General Revenue	26,549	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

INFORMATION SYSTEMS

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES	EE	0.00	5,697,417	19,851,039	0	25,548,456	
	Total	0.00	5,697,417	19,851,039	0	25,548,456	
DEPARTMENT CORE REQUEST	EE	0.00	5,697,417	19,851,039	0	25,548,456	
	Total	0.00	5,697,417	19,851,039	0	25,548,456	
GOVERNOR'S RECOMMENDED CORE	EE	0.00	5,697,417	19,851,039	0	25,548,456	
	Total	0.00	5,697,417	19,851,039	0	25,548,456	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
INFORMATION SYSTEMS								
CORE								
COMMUNICATION SERV & SUPP	11,267	0.00	898	0.00	898	0.00	898	0.00
PROFESSIONAL SERVICES	22,809,424	0.00	25,546,252	0.00	25,546,252	0.00	25,546,252	0.00
M&R SERVICES	1,117,669	0.00	1,306	0.00	1,306	0.00	1,306	0.00
TOTAL - EE	23,938,360	0.00	25,548,456	0.00	25,548,456	0.00	25,548,456	0.00
GRAND TOTAL	\$23,938,360	0.00	\$25,548,456	0.00	\$25,548,456	0.00	\$25,548,456	0.00
GENERAL REVENUE	\$5,395,629	0.00	\$5,697,417	0.00	\$5,697,417	0.00	\$5,697,417	0.00
FEDERAL FUNDS	\$18,542,731	0.00	\$19,851,039	0.00	\$19,851,039	0.00	\$19,851,039	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Information Systems

Program is found in the following core budget(s): Information Systems

1. What does this program do?

PROGRAM SYNOPSIS: Processes fee for service claims and managed care encounter data through a contractor for the Medicaid Management Information Systems (MMIS). It also provides for operation of the Medicaid Fraud and Abuse Detection System.

The Information Systems (IS) program area includes the MMIS contract and the Medicaid Fraud and Abuse Detection System (FADS). The primary function of Information Systems is to provide the tools and data needed to support administrative and financial decisions and to process fee-for-service claims and MC+ managed care encounter data. IS focuses on the gathering, maintenance, analysis, and output of information and data related to claims and a multitude of claims-related interfaces. It is additionally responsible for providing the software and hardware support needed to measure, analyze, assess and manipulate this information in the process of decision making and formulating and testing new systems.

The State contracts with a private entity to operate the subsystems of the Medicaid Management Information System. The subsystems include Claims Processing, Management and Analysis Reporting, Surveillance and Utilization, Reference, Provider, Recipient, Third Party Liability and Financial. In order to maintain quality management of Medicaid claims, the Division of Medical Services requires the fiscal agent to:

- ♦ Maintain and enhance a highly automated Medicaid claims processing and information retrieval system.
- ♦ Process Medicaid claims involving over 21,983 providers of 72 different types, such as hospitals, physicians, dentists, ambulance service providers, nursing homes, therapists, hospices, and managed care health plans.
- ♦ Perform manual tasks associated with processing Medicaid claims, and to retrieve and produce utilization and management information that is required by the Division and/or various agencies within the federal government. For example, quarterly utilization reports are generated for the Program Integrity to allow staff to detect and investigate over-utilization patterns and abuse. Third Party Liability (TPL) reports are produced that allow tracking of cost avoidance on claims and provide the capability to perform cost recovery functions.
- ♦ Provide capabilities and/or communications with the Department and the Division via on-line data links to facilitate transfers of data and monitoring of contract issues using menu driven reports and communications via electronic mail.
- ♦ Provide technical support to MC+ managed care health plans in the maintenance of data lines and the transfer of daily enrollment files and encounter data.

The MMIS is run on a mainframe computer system. There are approximately 25 programmers employed by the fiscal agent to maintain and enhance this system. The Interactive Voice Response (IVR) has the availability of approximately 70 incoming lines. The IVR hardware and software allows immediate access to eligibility, payment and claim status information. The Imaging System and REI data entry equipment allow claims storage and direct on-line claims processing and resolution.

The state began contracting MMIS with a contractor in 1979. The current MMIS contract was rebid in FY2001. It is a seven year contract, renewable for two one-year extensions. The contract for the fiscal agent specifies that reimbursement consists of a fixed payment per month. This payment method gives the contractor an incentive to adjudicate claims correctly when initially submitted so that the cost of reprocessing claims with correctable errors is avoided.

Claims Processing

Claims processing changes with the two programs, the fee-for-service program versus the managed care program. Under the fee-for-service program, claims are processed for payment to the provider. Services under managed care which are covered by the capitation payment would not generate a claim. Whoever provides the service is reimbursed by a health plan in some way. The service still results in involvement by IS through the processing of encounter claims. An encounter claim is the same as a regular claim in terms of the information processed, such as patient identification, diagnosis and the service(s) provided; it is just not subject to payment. The Division of Medical Services needs the encounter claim to know what services are being provided to managed care clients, so encounter claims are transmitted by health plans to the fiscal agent where they are processed and the data is stored.

Managed Care Impact: The primary issue reflecting the increased demand on Information Systems with the advent of the MC+ managed care program is interfacing with numerous different data processing systems. The MMIS system must now "talk" to the system run by the enrollment contractor and each of the seven individual health plans that contract with the state for Medicaid managed care. Success of the MC+ managed care program is data-driven. The agency needs encounter data from the plans in order to see what services are being provided to agency clients, otherwise on-site audits of thousands of providers would be required. The biggest demand is staff time to work with individual health plans when they have system problems involving the processing of MC+ managed care information. The MMIS went through a third-phase enhancement process for Medicaid managed care, so the agency feels it has a good system for handling enrollment, encounter claims, and other processing requirements of managed care.

Average claims processing time continues to decrease due to electronic claims processing increases and also due to system improvements. In FY95, the average processing time was 3.03 days. In FY96, it improved to 2.15 days and remained about the same in FY97 at 2.22 days. The average processing time for adjudicating claims in FY99 was 1.81 days, in FY00 was 2.07 days, in FY01 was 1.24 days, in FY02 was 1.77 days, in FY03 was 1.53 days, in FY04 was 1.58 days, in FY05 was 1.24 days and in FY06 was .91 days.

Fraud and Abuse Detection System

The implementation of a Medicaid Fraud and Abuse Detection System (FADS) occurred in October 2004. The system is designed to maximize the return on investment in fraud and abuse programs. This system will assist staff in monitoring utilization and program compliance by providers and recipients within the Medicaid program on a post-payment basis to enforce Federal and State Medicaid policy and program restrictions.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.201; Federal law: Social Security Act Section 1902(a)(4) and 1903(a)(3); Federal Regulation 42 CFR Part 433 Subpart C

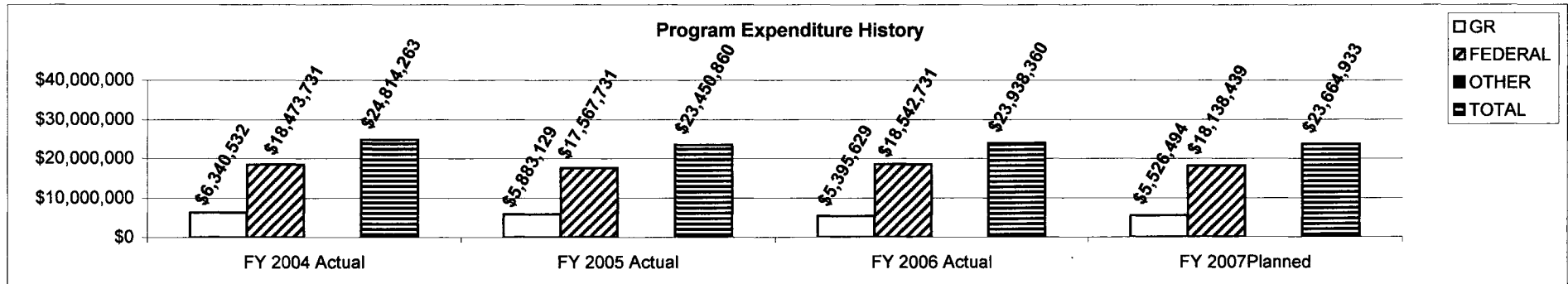
3. Are there federal matching requirements? If yes, please explain.

Expenditures for MMIS operations have three different federal financial participation (FFP) rates. The majority of MMIS expenditures earn 75% FFP and require 25% state share. Approved system enhancements earn 90% FFP and require 10% state share. Postage earns 50% FFP and requires 50% state share.

4. Is this a federally mandated program? If yes, please explain.

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.

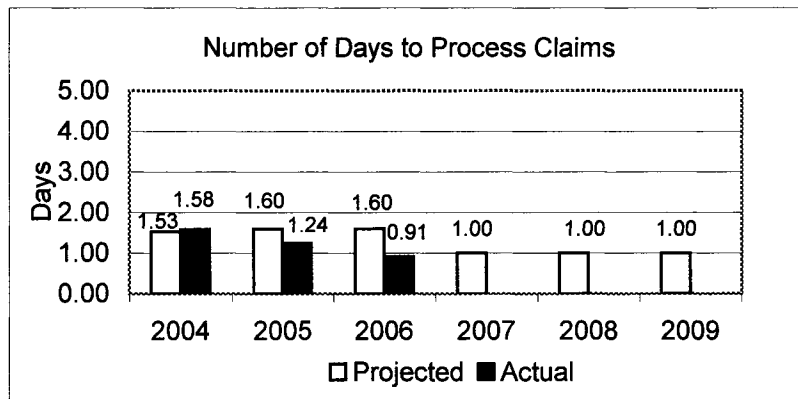
5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

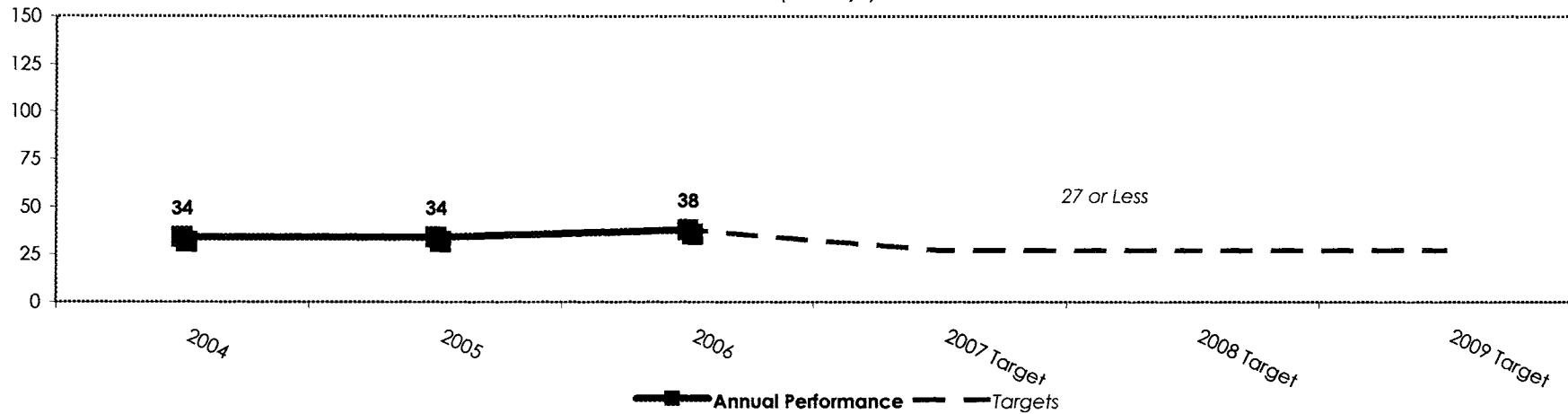
N/A

7a. Provide an effectiveness measure.



7b. Provide an efficiency measure.

Maintain Medicaid Provider Enrollment Application Backlog
(in Days)



7c. Provide the number of clients/individuals served, if applicable.

Payment Claims and Encounter Claims Processed		
SFY	Actual	Projected
2004	78.1 mil	79.5 mil
2005	82.0 mil	84.3 mil
2006	81.1 mil	86.1 mil
2007		85.2 mil
2008		89.4 mil
2009		93.9 mil

7d. Provide a customer satisfaction measure, if available.

NEW DECISION ITEM

RANK: 34

Department: Social Services
Division: Medical Services
DI Name: MMIS Modernization

Budget Unit: 90522C

DI#: 1886031

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE		34,940,000	5,660,000	40,600,000
PSD				
TRF				
Total		34,940,000	5,660,000	40,600,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE		34,940,000	5,660,000	40,600,000
PSD				
TRF				
Total		34,940,000	5,660,000	40,600,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Takeover and Reengineer MMIS	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: To takeover and reengineer Medicaid Management Information Systems (MMIS) after the current contract expires June 2009.

Funding is being requested because the current contract for the operation of the MMIS expires June 2009 at which time a reengineered MMIS will be acquired. A reengineered MMIS will require a minimum of 24 months from contract award (June 2007) to implement. The new system must be MITA (Medicaid Information Technology Architecture) compliant. MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise. Funding this decision item will allow the Missouri Medicaid, MC+ and SCHIP programs to continue to operate.

If unfunded, Medicaid claims processing, financial reporting and related operations will cease. The Federal Authority is Social Security Act Section 1902(a)(4) and 1903(a)(3); 42 CFR Part 433 Subpart C. The State Authority is RSMo. 208.201.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The current MMIS is a legacy system that has been modified and enhanced for more than twenty years to the business requirements of the Missouri Medicaid program. The Division of Medical Services (DMS) has decided that the best solution is to issue a Request for Proposal (RFP) for takeover and reengineering of the MMIS. This will provide DMS with the means to mitigate the major weaknesses in the current MMIS by providing a system that is more easily modified through use of a rules-engine and relational data base and other modifications. The reengineered system will be more efficient for the provider community and will improve provider satisfaction in Medicaid. It will also be better at meeting federal standards like HIPAA and MITA and will be more flexible, responsive and reliable in operation.

Below is the initial estimates of the costs to takeover and reengineer MMIS.

	Total	Federal	Other Funds
MMIS Takeover Cost	\$3,000,000	\$2,700,000	\$300,000
Design Development & Implementation MMIS	\$30,000,000	\$27,000,000	\$3,000,000
Upgrade Desktops and Network	\$1,600,000	\$1,440,000	\$160,000
IV&V and BPR Contractor	\$2,000,000	\$1,800,000	\$200,000
State Staff Time for Implementation	\$4,000,000	\$2,000,000	\$2,000,000
MMIS System Total	\$40,600,000	\$34,940,000	\$5,660,000

The majority of the costs use federal matching rate of 90%. The staff time costs use federal matching rate of 50%.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)			34,940,000		5,660,000		40,600,000		
Total EE	0		34,940,000		5,660,000		40,600,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	34,940,000	0.0	5,660,000	0.0	40,600,000	0.0	0

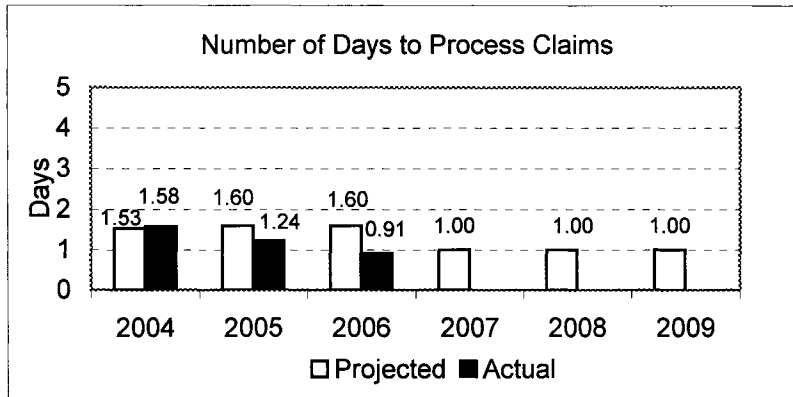
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5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

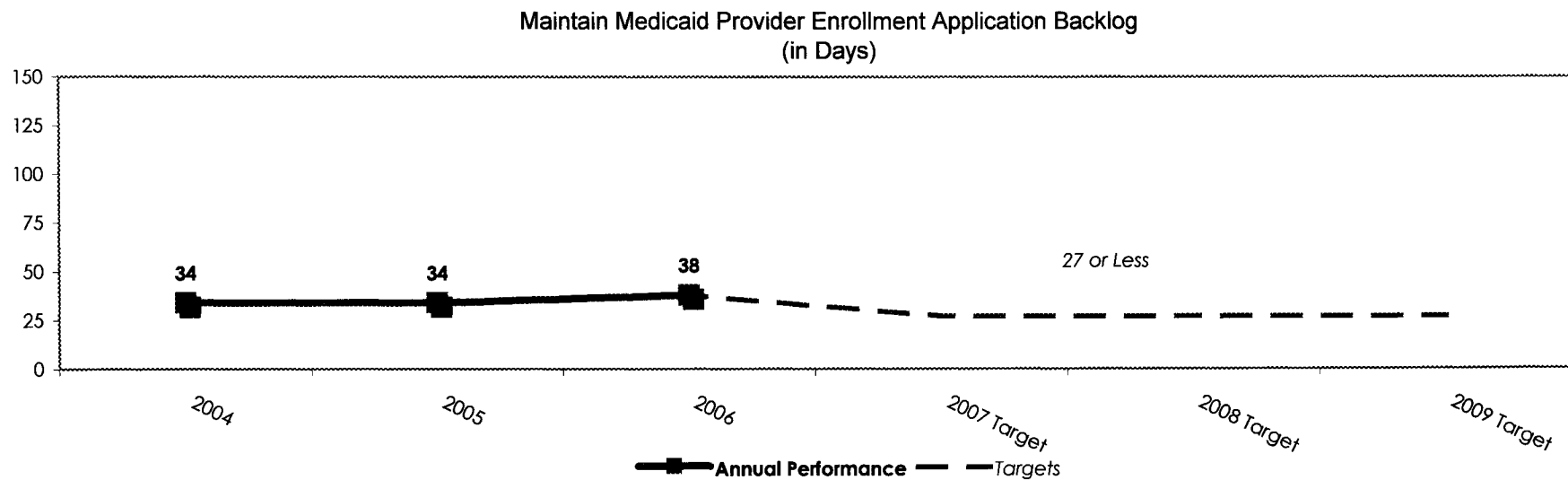
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services (400)			34,940,000		5,660,000		40,600,000		
Total EE	0		34,940,000		5,660,000		40,600,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	34,940,000	0.0	5,660,000	0.0	40,600,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.



6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

Payment Claims and Encounter Claims Processed		
SFY	Actual	Projected
2004	78.1 mil	79.5 mil
2005	82.0 mil	84.3 mil
2006	81.1 mil	86.1 mil
2007		85.2 mil
2008		89.4 mil
2009		93.9 mil

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Eliminate manual processing of provider forms by implementing automated processes.
- Maintain unit staffing.
- Continue to inform providers of their ability to enroll and/or access information including provider manuals, billing booklets and bulletins via the internet through the emomed.com or the Medicaid web site.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
INFORMATION SYSTEMS								
MMIS Modernization - 1886031								
PROFESSIONAL SERVICES	0	0.00	0	0.00	40,600,000	0.00	40,600,000	0.00
TOTAL - EE	0	0.00	0	0.00	40,600,000	0.00	40,600,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$40,600,000	0.00	\$40,600,000	0.00
GENERAL REVENUE								
	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS								
	\$0	0.00	\$0	0.00	\$34,940,000	0.00	\$34,940,000	0.00
OTHER FUNDS								
	\$0	0.00	\$0	0.00	\$5,660,000	0.00	\$5,660,000	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MC+ ENROLLMENT								
CORE								
EXPENSE & EQUIPMENT								
DEPT OF SOC SERV FEDERAL & OTH	1,587,162	0.00	1,910,113	0.00	1,910,113	0.00	1,910,113	0.00
TOTAL - EE	1,587,162	0.00	1,910,113	0.00	1,910,113	0.00	1,910,113	0.00
TOTAL	1,587,162	0.00	1,910,113	0.00	1,910,113	0.00	1,910,113	0.00
GRAND TOTAL	\$1,587,162	0.00	\$1,910,113	0.00	\$1,910,113	0.00	\$1,910,113	0.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: MC+ Enrollment

Budget Unit: 90525C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE		1,910,113		1,910,113
PSD				
TRF				
Total		1,910,113		1,910,113
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE		1,910,113		1,910,113
PSD				
TRF				
Total		1,910,113		1,910,113
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

2. CORE DESCRIPTION

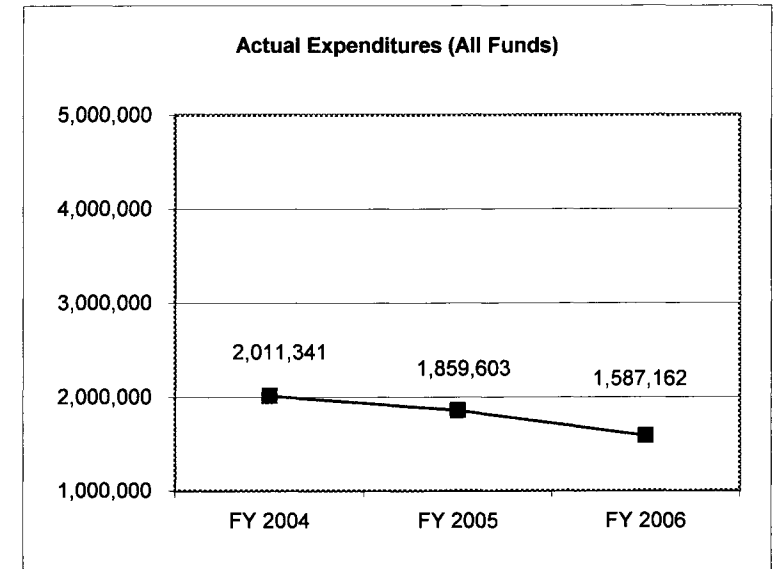
This core request is for the continued funding of the Health Benefit Manager (HBM) contract. The enrollment contract provides all enrollment services, client outreach, and education for the Managed Care program.

3. PROGRAM LISTING (list programs included in this core funding)

Managed Care Enrollment

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	3,214,472	1,998,558	1,910,113	1,910,113
Less Reverted (All Funds)	(3,131)	(2,653)	0	N/A
Budget Authority (All Funds)	3,211,341	1,995,905	1,910,113	N/A
Actual Expenditures (All Funds)	2,011,341	1,859,603	1,587,162	N/A
Unexpended (All Funds)	1,200,000	136,302	322,951	N/A
Unexpended, by Fund:				
General Revenue	0	5,668	0	N/A
Federal	1,200,000	130,634	322,951	N/A
Other	0	0	0	N/A
	(1)		(2)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Agency reserve of \$1,200,000 due to savings from contract rebid taken as a core cut in FY 2005.

(2) SB 539 eligibility reductions.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**MC+ ENROLLMENT**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES	EE	0.00	0	1,910,113	0	1,910,113	
	Total	0.00	0	1,910,113	0	1,910,113	
DEPARTMENT CORE REQUEST	EE	0.00	0	1,910,113	0	1,910,113	
	Total	0.00	0	1,910,113	0	1,910,113	
GOVERNOR'S RECOMMENDED CORE	EE	0.00	0	1,910,113	0	1,910,113	
	Total	0.00	0	1,910,113	0	1,910,113	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MC+ ENROLLMENT								
CORE								
PROFESSIONAL SERVICES	1,587,162	0.00	1,910,113	0.00	1,910,113	0.00	1,910,113	0.00
TOTAL - EE	1,587,162	0.00	1,910,113	0.00	1,910,113	0.00	1,910,113	0.00
GRAND TOTAL	\$1,587,162	0.00	\$1,910,113	0.00	\$1,910,113	0.00	\$1,910,113	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$1,587,162	0.00	\$1,910,113	0.00	\$1,910,113	0.00	\$1,910,113	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: MC+ Enrollment

Program is found in the following core budget(s): MC+ Enrollment

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for the Health Benefit Manager Contract. The contractor provides all enrollment services for the MC+ managed care program.

In 1995, Missouri began enrolling certain Medicaid recipients into managed care plans as the result of receiving a 1915(b) waiver. In 1998, Missouri received approval of an 1115 waiver (see separate 1115 waiver program description). Waiver eligibles in managed care areas enroll in managed care health plans.

Missouri contracts with a Health Benefits Manager (HBM) to provide enrollment services. The HBM contractor is responsible for managed care enrollment activities. The HBM gathers essential data at the time of enrollment or transfer, such as health risk assessment information. The health risk assessment information is passed to the health plan, which assists the health plan in reaching high risk and special needs clients.

The contractor is responsible for training and recruiting their staff and providing all office equipment and systems equipment necessary to provide enrollment services. With a responsive enrollment process, providers will have confidence in the system and the enrollment process will not be a source of provider dissatisfaction with the MC+ Managed Care program.

Missouri operates the MC+ Managed Care program under a 1915(b) waiver which allows for mandatory enrollment in an MC+ Managed Care health plan. Managed Care enrollees have a twelve month lock-in to provide a solid continuum of care. Once an enrollee chooses an MC+ Managed Care health plan or is assigned to an MC+ Managed Care health plan, the enrollee has ninety days in which to change health plans for any reason. After the ninety day period, the enrollee will be allowed to change MC+ Managed Care health plans for good cause as determined by the state agency at any time within the twelve month lock-in. Children within the care and custody of the state are allowed automatic and unlimited changes in MC+ Managed Care health plan choice as often as circumstances necessitate. With a MC+ Managed Care population of 379,795 in FY06, the maintenance efforts on the part of the HBM will be significant.

The current contractor is Policy Studies, Inc. The contractor is paid a firm, fixed price per member, per month.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.166; Federal law: Social Security Act Section 1915(b), 1115 Waiver; Federal Regulation: 42 CFR 438

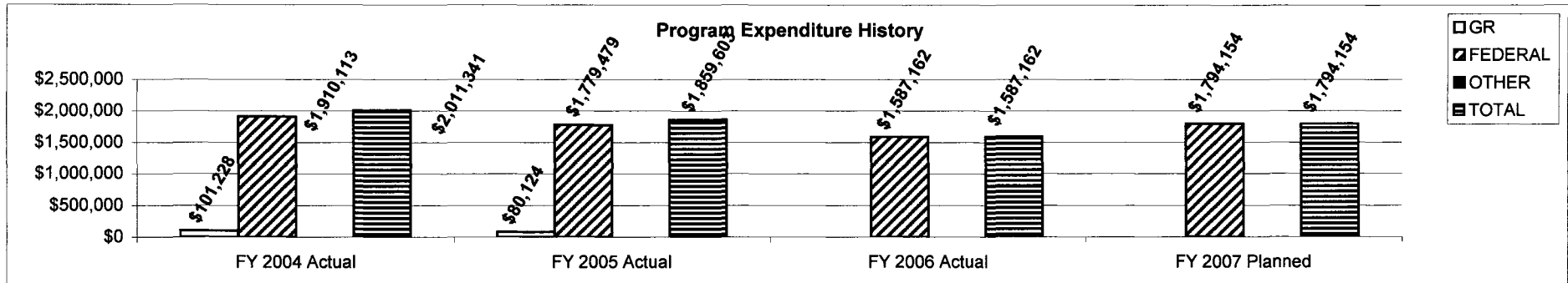
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

Percent of Enrollees Who Chose Their Own Plan		
SFY	Actual	Projected
2004	94.52%	90.00%
2005	94.18%	95.00%
2006	92.48%	95.00%
2007		95.00%
2008		95.00%
2009		95.00%

7c. Provide the number of clients/individuals served, if applicable.

Average Managed Care Monthly Enrollees		
SFY	Actual	Projected
2004	434,749	439,250
2005	437,176	461,213
2006	379,795	441,547
2007		371,895
2008		356,734
2009		349,314

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HC HOME ENROLLMENT								
Health Care Home Enrollment - 1886061								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	2,500,000	0.00
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	0	0.00	0	0.00	2,500,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	5,000,000	0.00
TOTAL	0	0.00	0	0.00	0	0.00	5,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$5,000,000	0.00

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**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Health Care Home Enrollment Broker

Budget Unit: 90526C
DI#: 1886061

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	2,500,000	2,500,000		5,000,000
PSD				
TRF				
Total	2,500,000	2,500,000		5,000,000
FTE				0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding is recommended for a contract with an enrollment broker to help MO HealthNet participants select a health care home and a health care home coordinator.

As part of the tranformation of Medicaid, participants will be asked to take a more active roll in their health care. Participants will be asked to identify a health care home. The health care home will assist participants and their support system with accessing primary care services, coordinating referrals and obtaining specialty care. Funding is requested for an enrollment broker who will work with the participant in a preliminary SF-8 assessment to help the client choose a health care home and a health care home coordinator.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

An enrollment broker will assist the participant in choosing a health care home and a health care home coordinator. The estimated per capita fee of \$10 is based on the current enrollment broker function included in the Chronic Care Improvement Program contract. The broker will assist fee-for-service individuals in a preliminary SF-8 assessment to help the client choose a health care home and a health care home coordinator. Participants in managed care currently receive help choosing their primary care provider. The fee-for-service population was multiplied by the annual fee to arrive at the cost of the broker contract. 500,000 x \$10 = \$5,000,000

	Total	GR	Federal
Enrollment Broker	\$5,000,000	\$2,500,000	\$2,500,000

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

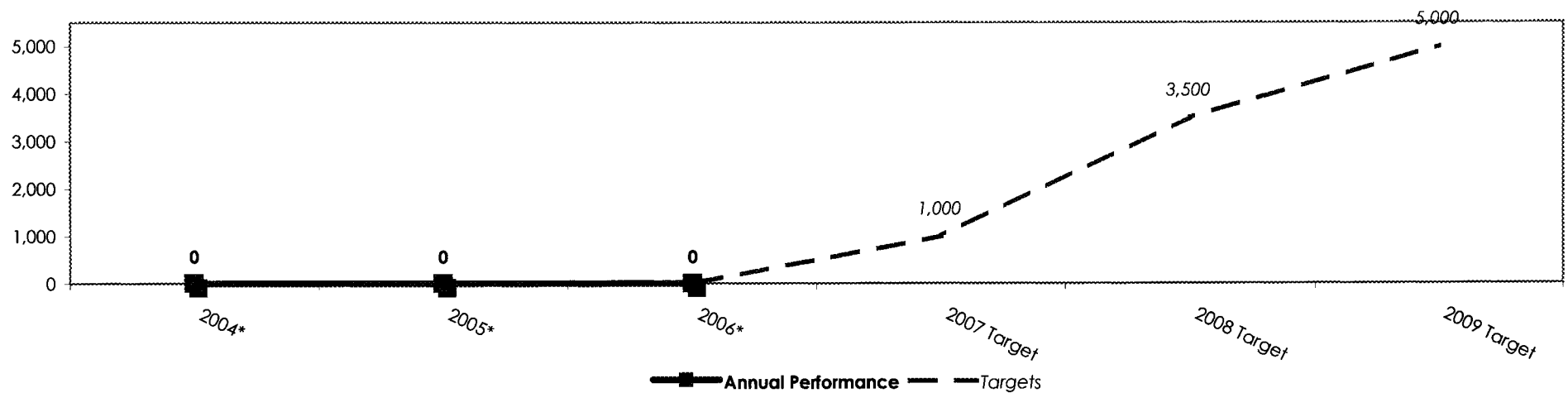
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	2,500,000 2,500,000		2,500,000 2,500,000		0		5,000,000 5,000,000		0
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	2,500,000	0.0	2,500,000	0.0	0	0.0	5,000,000	0.0	0

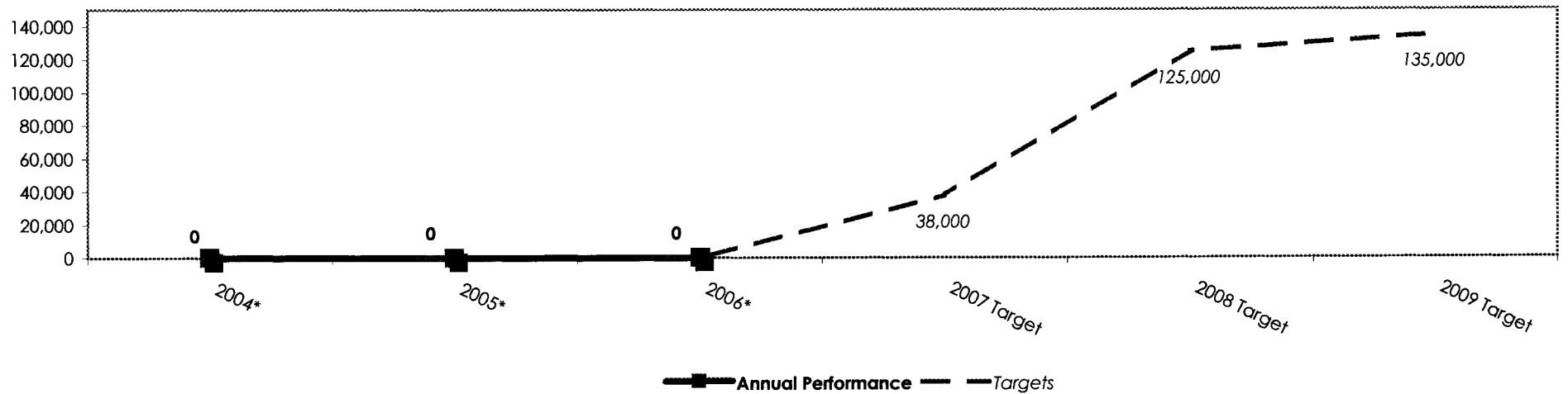
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

Increase Medicaid Providers Participating in a Chronic Care Improvement Program



Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Identify providers currently serving the targeted population to invite them to participate in the chronic care improvement program.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of their participation as well as showing providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.
- Evaluate edits causing the largest denials.
- Post on the Internet the most common billing errors and how to avoid them.
- Conduct provider education seminars.
- Assure provider manuals are updated timely.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HC HOME ENROLLMENT								
Health Care Home Enrollment - 1886061								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	5,000,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	5,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$5,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$2,500,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$2,500,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
PHARMACY									
CORE									
EXPENSE & EQUIPMENT									
TITLE XIX-FEDERAL AND OTHER	74,385	0.00	0	0.00	0	0.00	0	0.00	
TOTAL - EE	74,385	0.00	0	0.00	0	0.00	0	0.00	
PROGRAM-SPECIFIC									
GENERAL REVENUE	204,737,780	0.00	138,209,439	0.00	135,282,533	0.00	135,282,533	0.00	
TITLE XIX-FEDERAL AND OTHER	559,936,594	0.00	415,079,815	0.00	409,334,365	0.00	409,334,365	0.00	
PHARMACY REBATES	88,164,532	0.00	37,257,750	0.00	37,257,750	0.00	37,257,750	0.00	
THIRD PARTY LIABILITY COLLECT	5,364,715	0.00	5,271,334	0.00	5,271,334	0.00	5,271,334	0.00	
PHARMACY REIMBURSEMENT ALLOWAN	41,150,896	0.00	23,498,486	0.00	23,493,486	0.00	23,493,486	0.00	
HEALTH INITIATIVES	940,214	0.00	969,293	0.00	969,293	0.00	969,293	0.00	
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	1,041,034	0.00	1,041,034	0.00	
HFT-HEALTH CARE ACCT	864,322	0.00	1,041,034	0.00	0	0.00	0	0.00	
LIFE SCIENCES RESEARCH TRUST	0	0.00	38,500,000	0.00	0	0.00	0	0.00	
PREMIUM	0	0.00	3,800,000	0.00	3,800,000	0.00	3,800,000	0.00	
TOTAL - PD	901,159,053	0.00	663,627,151	0.00	616,449,795	0.00	616,449,795	0.00	
TOTAL	901,233,438	0.00	663,627,151	0.00	616,449,795	0.00	616,449,795	0.00	
Replace Life Science Trust Fun - 1886032									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	38,500,000	0.00	38,500,000	0.00	
TOTAL - PD	0	0.00	0	0.00	38,500,000	0.00	38,500,000	0.00	
TOTAL	0	0.00	0	0.00	38,500,000	0.00	38,500,000	0.00	
Medicaid Caseload Growth - 1886033									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	835,982	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,376,781	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	2,212,763	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	2,212,763	0.00	0	0.00	
Pharmacy PMPM Increase - 1886034									
PROGRAM-SPECIFIC									

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Pharmacy PMPM Increase - 1886034								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	37,770,869	0.00	28,345,827	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	62,204,961	0.00	46,682,832	0.00
TOTAL - PD	0	0.00	0	0.00	99,975,830	0.00	75,028,659	0.00
TOTAL	0	0.00	0	0.00	99,975,830	0.00	75,028,659	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	925,120	0.00	925,120	0.00
TOTAL - PD	0	0.00	0	0.00	925,120	0.00	925,120	0.00
TOTAL	0	0.00	0	0.00	925,120	0.00	925,120	0.00
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	79,319	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	130,631	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	209,950	0.00
TOTAL	0	0.00	0	0.00	0	0.00	209,950	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	2,950,114	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	4,858,553	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,808,667	0.00
TOTAL	0	0.00	0	0.00	0	0.00	7,808,667	0.00
Provider Tax GR Replacement - 1886066								
PROGRAM-SPECIFIC								

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Provider Tax GR Replacement - 1886066								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	5,000	0.00	5,000	0.00
TOTAL - PD	0	0.00	0	0.00	5,000	0.00	5,000	0.00
TOTAL	0	0.00	0	0.00	5,000	0.00	5,000	0.00
GRAND TOTAL	\$901,233,438	0.00	\$663,627,151	0.00	\$758,068,508	0.00	\$738,927,191	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Pharmacy

Budget Unit: 90541C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	135,282,533	409,334,365	71,832,897	616,449,795
TRF				
Total	135,282,533	409,334,365	71,832,897	616,449,795
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Life Sciences Research Trust Fund (0763)
Pharmacy Rebates Fund (0114)
Third Party Liability Collections Fund (TPL) (0120)
Pharmacy Reimbursement Allowance Fund (0144)
Health Initiatives Fund (HIF) (0275)
Health Families Trust Fund-Health Care Account (HFTF) (0640)
Premium Fund (0885)

Notes: An "E" is requested for the \$37,257,750 Pharmacy Rebates Fund

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	135,282,533	409,334,365	71,832,897	616,449,795
TRF				
Total	135,282,533	409,334,365	71,832,897	616,449,795
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Life Sciences Research Trust Fund (0763)
Pharmacy Rebates Fund (0114)
Third Party Liability Collections Fund (TPL) (0120)
Pharmacy Reimbursement Allowance Fund (0144)
Health Initiatives Fund (HIF) (0275)
Health Families Trust Fund-Health Care Account (HFTF) (0640)
Premium Fund (0885)

Notes: An "E" is requested for the \$37,257,750 Pharmacy Rebates Fund

2. CORE DESCRIPTION

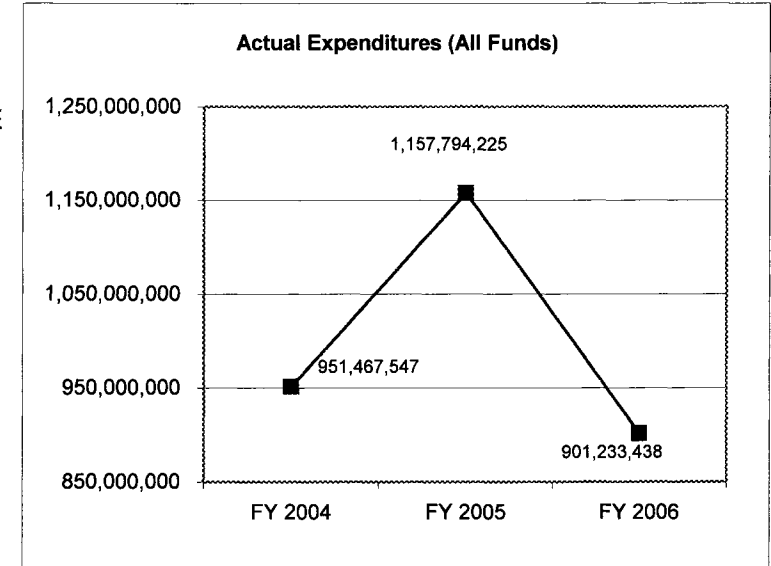
This core request is for the continued funding of the pharmacy fee-for-service program. Funding provides pharmacy services for the non-managed care Medicaid population. Funding is necessary to maintain pharmacy reimbursement at a sufficient level to ensure quality health care and provider participation.

3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.	
Appropriation (All Funds)	957,749,272	1,179,156,068	901,439,230	663,627,151	E
Less Reverted (All Funds)	(29,079)	(29,079)	(29,079)	N/A	
Budget Authority (All Funds)	957,720,193	1,179,126,989	901,410,151	N/A	
Actual Expenditures (All Funds)	951,467,547	1,157,794,225	901,233,438	N/A	
Unexpended (All Funds)	6,252,646	21,332,764	176,713	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	17,572,764	1	N/A	
Other	6,252,646	3,760,000	176,712	N/A	
	(1)	(2)	(3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

Prior to MMA, pharmacy services for dual eligibles were paid from this appropriation. Since January 2006 dual eligibles receive pharmacy thru Medicare Part D.

NOTES:

Estimated "E" appropriation for Pharmacy Rebates Fund for FY 2004 thru FY 2007.

(1) Lapse of \$1,170,330 is Pharmacy Rebates and \$5,082,316 is Pharmacy Reimbursement Allowance. There was no cash to support lapsed authority in Pharmacy Rebates and Pharmacy Reimbursement Allowance. Expenditures of \$55,667,493 were paid from the Supplemental Pool.

(2) Agency reserve of \$3,760,000 TPL fund. Lapse of \$17,572,764 in federal authority. Expenditures of \$5,079,767 were paid from the Supplemental Pool (GR).

(3) Agency reserve of \$176,712 Healthy Families Trust Fund-Health Care Account (HFT). Expenditures totaling \$408 were paid from the Supplemental Pool (Pharmacy Rebates).

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

PHARMACY

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			PD	0.00	138,209,439	415,079,815	110,337,897	663,627,151	
			Total	0.00	138,209,439	415,079,815	110,337,897	663,627,151	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1663 2525	PD		0.00	(2,926,906)	0	0	(2,926,906)	Core Cut -- MAWD
Core Reduction	1663 2526	PD		0.00	0	(4,820,330)	0	(4,820,330)	Core Cut -- MAWD
Core Reduction	1673 3051	PD		0.00	0	0	(38,500,000)	(38,500,000)	Core Cut Life Science Research Trust Fund
Core Reduction	1700 2526	PD		0.00	0	(925,120)	0	(925,120)	FMAP Adjustment
Core Reduction	3242 5586	PD		0.00	0	0	(5,000)	(5,000)	Core cut due to provider tax cap reduction
Core Reallocation	2126 5506	PD		0.00	0	0	(1,041,034)	(1,041,034)	Reallocation from #0640 to #0625
Core Reallocation	2126 3706	PD		0.00	0	0	1,041,034	1,041,034	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES				0.00	(2,926,906)	(5,745,450)	(38,505,000)	(47,177,356)	
DEPARTMENT CORE REQUEST									
		PD		0.00	135,282,533	409,334,365	71,832,897	616,449,795	
		Total		0.00	135,282,533	409,334,365	71,832,897	616,449,795	
GOVERNOR'S RECOMMENDED CORE									
		PD		0.00	135,282,533	409,334,365	71,832,897	616,449,795	
		Total		0.00	135,282,533	409,334,365	71,832,897	616,449,795	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
CORE								
PROFESSIONAL SERVICES	74,385	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	74,385	0.00	0	0.00	0	0.00	0	0.00
PROGRAM DISTRIBUTIONS	901,159,053	0.00	663,627,151	0.00	616,449,795	0.00	616,449,795	0.00
TOTAL - PD	901,159,053	0.00	663,627,151	0.00	616,449,795	0.00	616,449,795	0.00
GRAND TOTAL	\$901,233,438	0.00	\$663,627,151	0.00	\$616,449,795	0.00	\$616,449,795	0.00
GENERAL REVENUE	\$204,737,780	0.00	\$138,209,439	0.00	\$135,282,533	0.00	\$135,282,533	0.00
FEDERAL FUNDS	\$560,010,979	0.00	\$415,079,815	0.00	\$409,334,365	0.00	\$409,334,365	0.00
OTHER FUNDS	\$136,484,679	0.00	\$110,337,897	0.00	\$71,832,897	0.00	\$71,832,897	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Pharmacy

Program is found in the following core budget(s): Pharmacy

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for pharmacy services for fee for service Medicaid/MC+ recipients.

This Pharmacy Services appropriation provides funding for fee-for-service eligibles for prescription drugs produced by manufacturers for which there exists a rebate agreement between the manufacturer and the federal Department of Health and Human Services (HHS) and dispensed by qualified providers. Since January 1, 1991, Missouri Medicaid has provided reimbursement for all outpatient drugs (except for those which are specifically excluded or for which prior authorization is necessary) for which there is a manufacturer's rebate agreement. While over-the-counter preparations do not require a prescription for sale to the general public, a prescription for those selected types of over-the-counter products that qualify for Medicaid coverage is required in order for the product to be reimbursable. In general terms, Missouri Medicaid drug reimbursement is made at the lower of: the Wholesale Acquisition Cost (WAC) plus 10%; the Federal Upper Limit (FUL); the Missouri Maximum Acquisition Cost (MAC) plus the professional dispensing fee; or the billed charge.

The U.S. Congress created the Medicaid outpatient prescription drug rebate program when it enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The goal of the program is to reduce the cost of outpatient prescription drugs by requiring drug manufacturers to pay a rebate directly to State Medicaid programs. The purpose of the program is to reduce the cost of prescription drugs without placing an undue burden on pharmacies by requiring the drug manufacturers to pay a rebate directly to the state Medicaid programs. The intent of this rebate is to allow the state and federal governments to receive price reductions similar to those received by other high volume purchasers of drugs.

Rebate Program

OBRA '90 requires all drug manufacturers to enter into a drug rebate agreement with the Department of Health and Human Services before their product lines will be eligible for coverage by Medicaid. Currently, 500 manufacturers have signed agreements with Centers for Medicare and Medicaid Services (CMS) and participate in the Drug Rebate Program. Approximately 400 manufacturers have products dispensed and are invoiced quarterly. Once the drug manufacturer has entered into the agreement, the state Medicaid programs are required to provide coverage of the manufacturers' drug products. However, the state has the option of excluding certain categories of the manufacturer's products or requiring prior authorization for reimbursement of products. Manufacturers are required to calculate and make rebate payments to the state Medicaid agency for the manufacturer's covered outpatient drugs reimbursed by the state during each quarter. Manufacturers are to be invoiced no later than sixty days after the end of each calendar quarter and are required to make payment for the calculated drug rebate directly to the state Medicaid program within 38 days of invoicing. For generic drugs, the rebate amount is currently 11% of Average Manufacturer Price (AMP). For multi-source drugs, the rebate is the greater of 15% of AMP or the difference between the AMP and the manufacturer's "best price", plus CPI-U factors. The manufacturer has the option of disputing the calculated drug rebate amount if the manufacturer disagrees with the state's drug utilization data. The manufacturer is required to report the nature of the dispute to the state, and the state is then responsible for resolving the dispute through negotiation or a hearing process, if necessary. Approximately 40% of the total rebates collected are used as a state share funding source rather than using General Revenue funds. The approximate 60% federal share of the rebates collected is returned to the federal government.

Prior Authorization

Any covered outpatient drug can be subject to prior authorization. Effective August 1, 1992, a prior authorization (PA) process was implemented for certain specific drugs under the pharmacy program.

Drug prior authorization (PA) requests are received via telephone, fax, or mail. All requests for drug PA must be initiated by a physician or authorized prescriber (advanced practice nurse) with prescribing authority for the drug category for which a PA is being requested. As specified in OBRA 90, drug PA programs must provide a response by telephone or other telecommunication device within 24 hours of receipt. All requests must include all required information. Requests received with insufficient information for review or received from someone other than a physician will not initiate a PA review nor the 24-hour response period. Drug PA requests received via telephone are keyed on-line and notification of approval will be given at the time of the call or by return FAX or phone call. The Medicaid Technicians who staff this hotline work through algorithms developed by the Drug Prior Authorization Committee with the assistance of UMKC-DIC, School of Pharmacy. These algorithms are sets of questions used to make a determination to approve or deny the request. Making the prior authorization determination on-line allows the PA file to be updated immediately. For approvals, the requestor will be given an authorization period. Pharmacies may record this information for this purpose as well.

Board and Committee Support and Oversight

The Division of Medical Services operates both prospective and retrospective Drug Utilization Review (DUR) as required by federal and state law. The DUR program is focused on educating health care providers in the appropriate use of medications, and informing providers of potential drug therapy problems found in the review of drug and diagnostic information obtained from Medicaid claims history. The DUR Board is central to all DUR program activities, and its duties and membership requirements are specified in state and federal law. DUR Board members are appointed by the Governor with advice and consent of the Senate, and its 13 members include 6 physicians, 6 pharmacists, and one quality assurance nurse.

In an ongoing process, the DUR Board reviews and makes changes to the clinical therapeutic criteria used to generate prospective and retrospective DUR interventions. The DUR Board also advises the Division on other issues related to appropriate drug therapy, and produces a quarterly newsletter for providers on selected drug topics. In addition to the Board, there is a Regional DUR Committee. The regional committee is comprised of physicians and pharmacists who evaluate individual Medicaid patients' retrospective drug regimens and advise their providers on appropriate drug use or potentially problematic drug therapies.

The Medicaid Drug Prior Authorization (PA) Committee is established in state regulation. This advisory committee is charged with reviewing drugs and recommending those drugs which are appropriate for reimbursement as a regular benefit verses those which should be placed on prior authorization status. All such recommendations made by the Drug PA Committee are referred to the DUR Board, as they are the statutorily-appointed advisory group for final recommendation to the Division.

Cost Containment Initiatives

As a result of new drugs, rapidly changing prescribing patterns, and increased expenditures in the Missouri Medicaid fee-for-service pharmacy program, the Medicaid program continues to implement a number of administrative measures to ensure the economic and efficient provision of the Medicaid pharmacy benefit. These strategies have been developed through recommendations from a number of sources, including affected state agencies, provider groups, and the pharmaceutical industry. The intent of these initiatives is to ensure that Medicaid recipients get the right drug to meet their needs, in the right amount, and for the right period of time. Examples of some of the cost containment initiatives include:

31-Day Maximum Supply: Effective for dates of service on or after December 1, 2000, the State agency implemented a 31-day maximum supply restriction on claims submitted for prescriptions dispensed to Missouri Medicaid recipients. Pharmacy claims submitted for a days supply greater than allowed under this policy will be denied. The following categories are exempt from this restriction: antiretroviral agents, oral contraceptives, children's vitamins, prenatal vitamins, and drug products limited by packaging requirements.

Expanded Missouri Maximum Allowable Cost (MAC) List: The list of drugs for which the state agency has established a generic reimbursement limit will be monitored and expanded on a regular basis. A mechanism is in place to review existing MACs as well as identifying new generic drugs for addition to this list, as they become available. This optimizes generic utilization in the Medicaid program.

Unique Prescriber Number: Effective for dates of service on or after December 1, 2001, the Medicaid pharmacy claims filing process requires the Missouri Medicaid provider number, DEA number or NPI (when available) in the prescriber identification field. Claims submitted on or after that date that do not identify the prescriber's Missouri Medicaid provider number, DEA number or NPI will be rejected.

Edits - Early Refill: Effective for claims submitted on or after March 18, 2002, the ability of pharmacy providers to manually override claims denied for the early refill edit, has been revoked. Providers must now contact the help desk in order to obtain an override for payment of claims being denied for the early refill edit.

Edits - Dose Optimization: Effective for dates of service on or after April 16, 2002, claims submitted to the Missouri Medicaid Pharmacy Program will be subject to edits to identify claims for pharmacy services that fall outside expected patterns of use for certain products. Overrides to these edit denials can be processed through the help desk. Justification for utilization outside expected patterns such as FDA approved labeling will be required for approval of such an override.

Pharmacy Provider Tax: The Missouri General Assembly recently passed legislation establishing a tax on licensed retail pharmacies in Missouri for the privilege of providing outpatient prescription drugs. The tax is based on the information obtained in an affidavit sent to pharmacies in June 2002, including monthly gross retail prescription pharmacy receipts. The Department of Social Services has notified each pharmacy of the amount of tax due. The first payment was due August 15, 2002. This tax may be withheld from each pharmacy's Medicaid check through an offset or the pharmacy may send a check or money order. Effective July 1, 2002, Missouri pharmacies were given an enhanced dispensing fee of \$3.95, for a total dispensing fee of \$8.04.

Coverage of Over-the-Counter Medications: This program monitors the product utilization to detect shifts in the prescribing patterns from deleted OTC drugs to more expensive prescription products. The program has now determined areas in which the shift is occurring and thus where cost savings could be achieved if specific and limited OTC drugs are covered. The program continues to monitor the product utilization to detect shifts in the prescribing patterns from deleted OTC drugs to more expensive prescription products. The program has now determined areas in which the shift is occurring and thus where cost savings could be achieved if specific and limited OTC drugs are covered.

Prior Authorization of All New Drugs: Effective July 1, 2002, prior authorization is required for all new drug entities and new drug product dosage forms of existing drug entities that have been approved by the Food and Drug Administration and are available on the market. After identifying these products through First Data Bank's weekly updates, the medications are reviewed for medical and clinical criteria along with pharmacoeconomic impact to the pharmacy program.

Enhanced Retrospective Drug Utilization: Enhanced Retrospective Drug Utilization involves retroactively reviewing population based patterns of drug use to compare those patterns to approved therapeutic guidelines in order to determine the appropriateness of care, length of treatment, drug interaction, and other clinical issue.

Provider Audits: Daily provider audits are performed by DMS/IFOX staff for the identification and resolution of potential recoupments.

Enhanced pharmacy contract: Given the financial constraints on the state's Medicaid budget, the high cost of treating chronically ill patients, and the desire to improve patient outcomes and health status, the Division of Medical Services has awarded a one year contract (with renewal options) to ACS-Heritage Information Systems, Inc. of Richmond, Virginia, to provide enhanced pharmacy services consisting of the following 3 (three) components:

- ♦ **Disease Management** - This initiative is a proactive approach designed to meet the comprehensive needs of the individual that will slow the progression of chronic disease and avoid medical crises to the greatest possible degree. Based on a cooperative physician and pharmacist team recruited by Heritage, the disease management program will be designed to deliver services to patients with a goal of achieving improved patient care, improved patient outcomes, reduced inpatient hospitalization, reduced emergency room visits, lower total cost, and better educated provider and patients.
- ♦ **Fiscal and Clinical Edits** - This initiative will optimize the use of program funds and enhance patient care through improved use of pharmaceuticals. Since the implementation of the Omnibus Budget Reduction Act of 1990 (OBRA 90), education on the use of pharmaceuticals has been accomplished primarily through DUR. However, the prospective DUR alerts currently generated by the fiscal agent (Verizon) have been largely ignored by pharmacy providers as they are more general in nature and few are tied to claim reimbursement. Other third party payors have successfully utilized more extensive evidence based claims screening edits in an effort to control costs. Such edits are applicable within the Medicaid program to achieve similar cost controls.

Point-of-service pharmacy claims will be routed through Heritage's automated system to apply edits specifically designed to assure effective utilization of pharmaceuticals. The edits will be founded on evidence-based clinical and nationally recognized expert consensus criteria. Claims will continue to be processed by Verizon for all other edits and final adjudication. After processing by Heritage and Verizon, the claim will be sent back to the provider with a total processing time of approximately 10 seconds. Claims which are denied by the system edits will require an override from the existing help desk. Providers seeking an override must contact the help desk for approval, which will be granted if medically necessary.

- ♦ **Drug Utilization Review** - This process is currently provided by Heritage, and will be an extension of the current process with some enhancements. Under the new contract, this initiative will utilize the same database / computer system as for the previously described components. This system uses a relational database capable of interfacing Medicaid paid claims history with flexible, high quality clinical evaluation criteria. The process will be designed to identify high-risk drug use patterns among physicians, pharmacists, and beneficiaries, and to educate providers (prescribers and dispensers) in appropriate and cost-effective drug use. This process will also be capable of identifying providers prescribing and dispensing practices which deviate from defined standards, as well as generate provider profiles and ad hoc reports for specified provider and recipient populations. The goal of the program will be to maximize drug therapy and outcomes, and optimize expenditures for health care.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State: RSMo. 208.152, 208.166, Federal law: Social Security Act Section 1902(a)(12), Federal regulation: 42 CFR 440.120

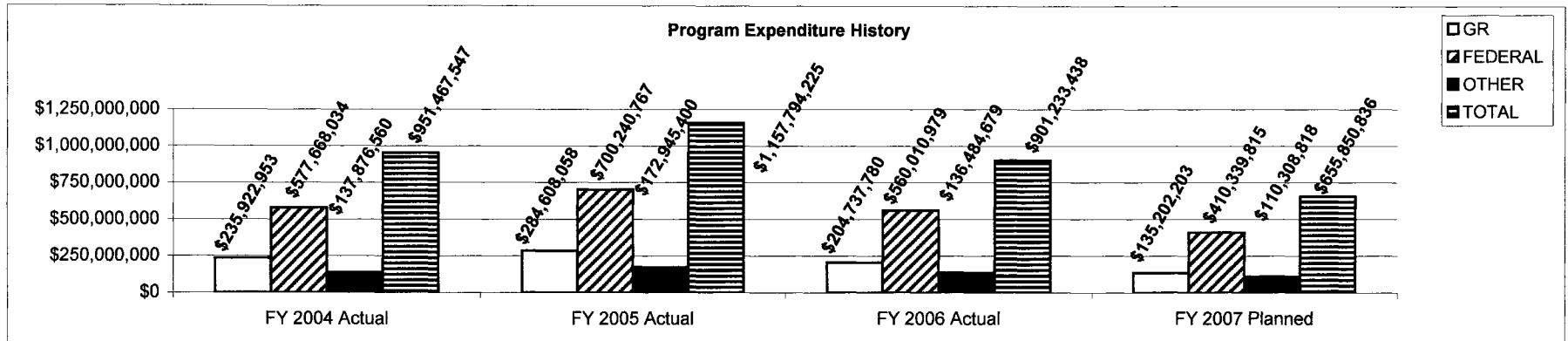
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Yes for children. No for adults.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

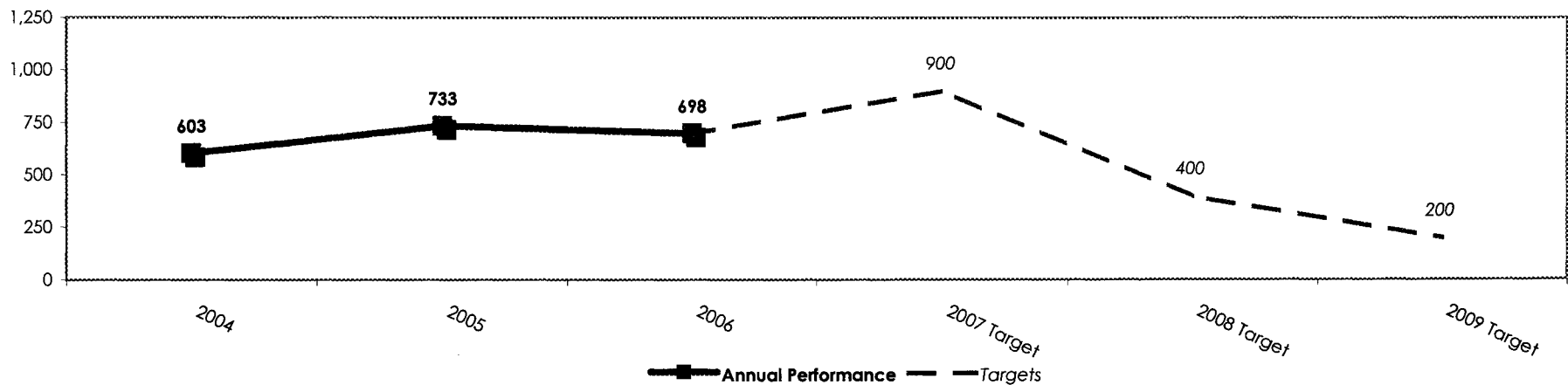


6. What are the sources of the "Other" funds?

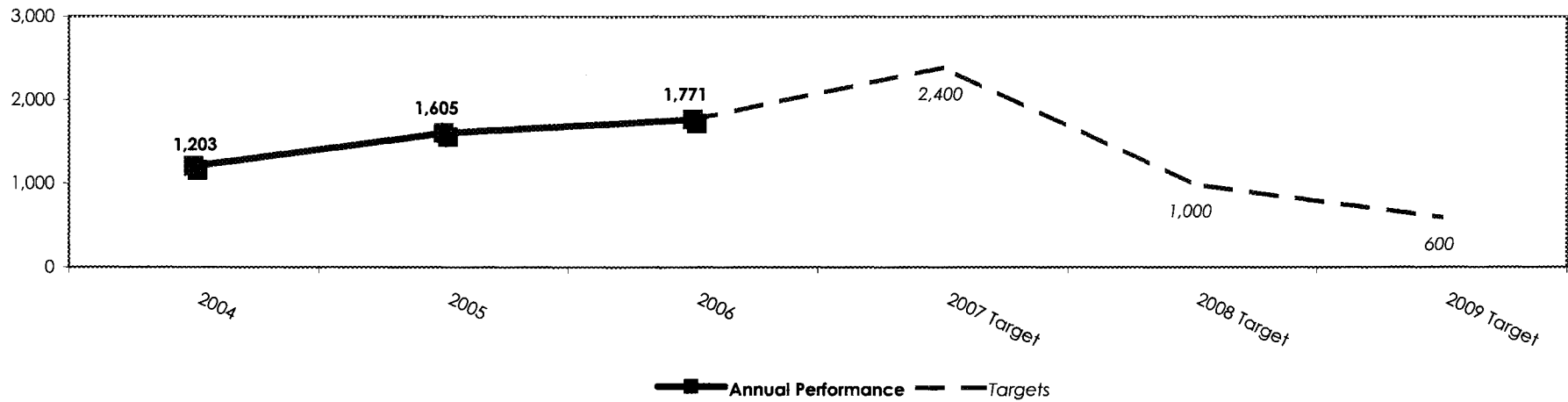
Pharmacy Reimbursement Allowance Fund (0144), Pharmacy Rebates Fund (0114), Health Initiatives Fund (0275), Healthy Families Trust Fund-Health Care Account (0640), Third Party Liability Fund (0120).

7a. Provide an effectiveness measure.

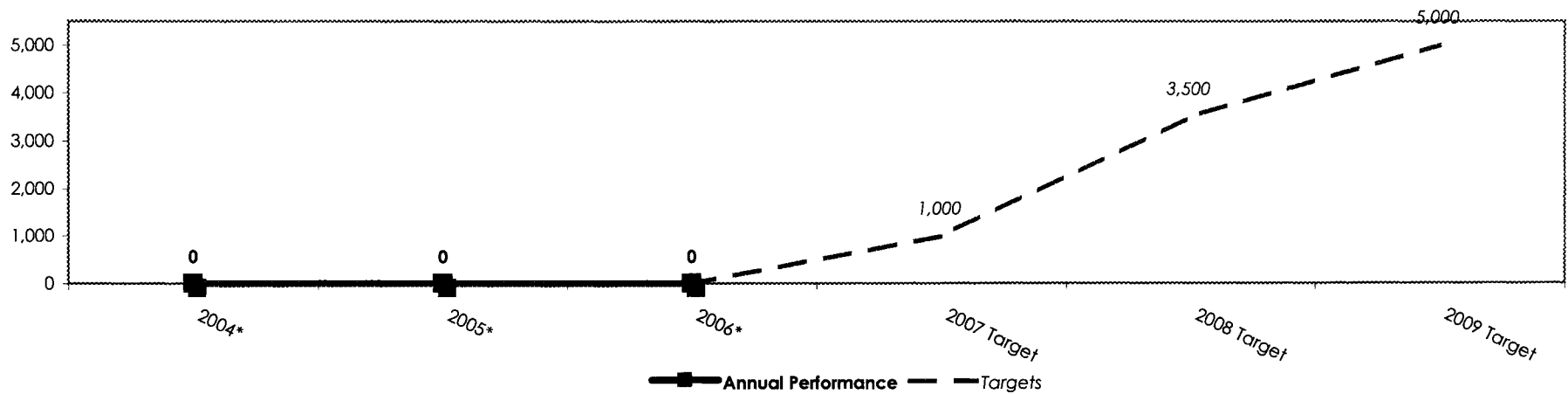
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

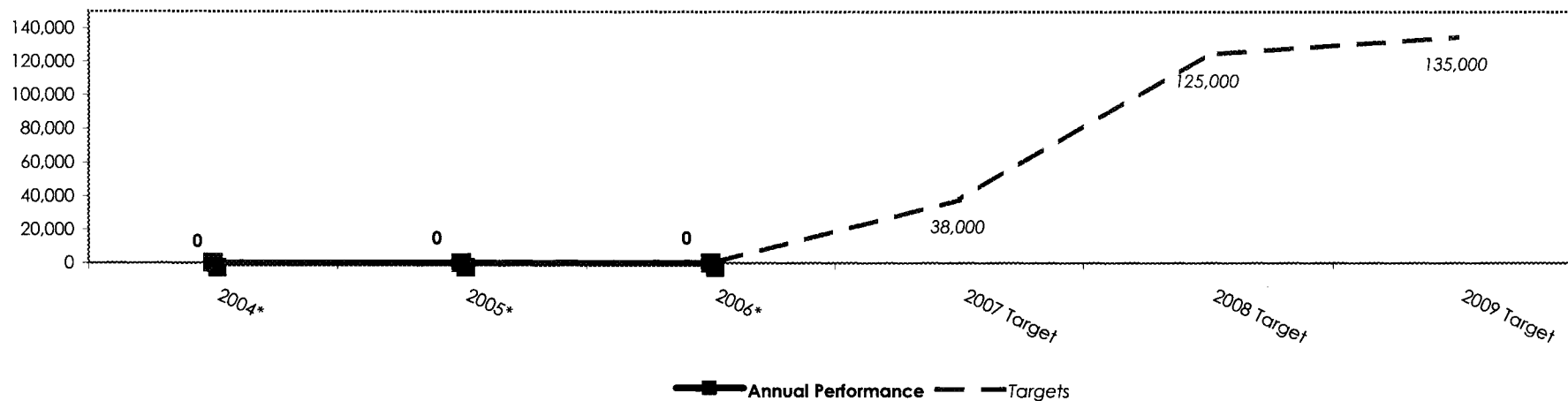


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

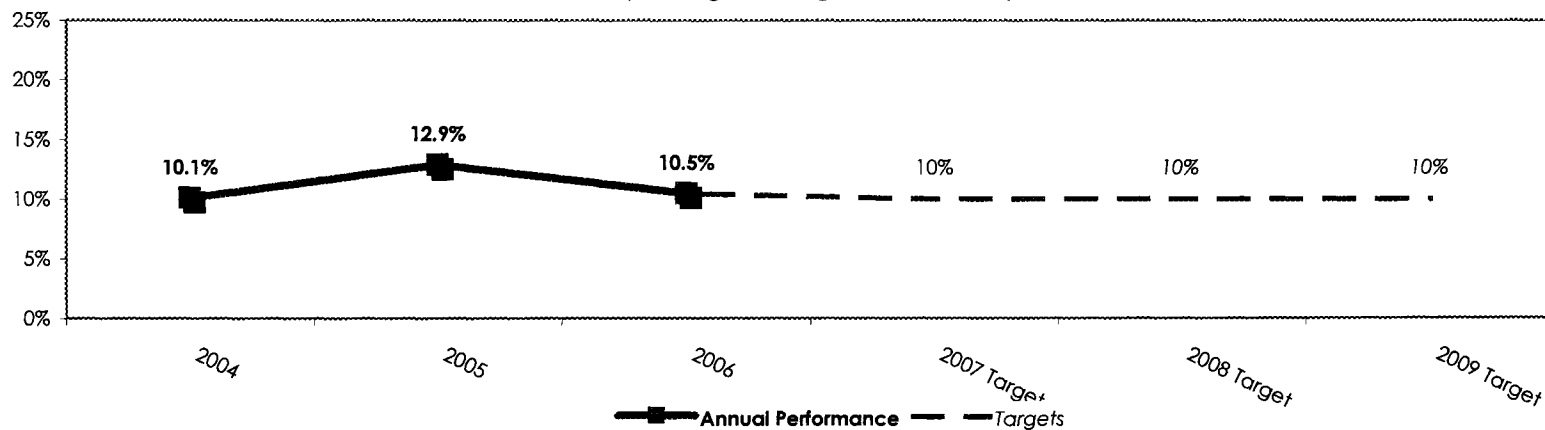
Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

Maintain the Percentage Increase in Pharmacy Expenditures (Average Per Eligible Per Month)



7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Pharmacy services are available to all Medicaid eligibles. In the regions of the state where MC+ managed care has been implemented, enrollees have pharmacy services available through the MC+ managed care health plans.

Average Monthly Pharmacy Users		
SFY	Actual	Projected
2004	272,828	
2005	291,081	293,290
2006	243,447	240,300
2007		188,900*
2008		214,400
2009		239,900

*Reduction in FY07 due to the MMA

Number of Pharmacy Claims		
SFY	Actual	Projected
2004	17.1 mil	16.5 mil
2005	19.1 mil	18.8 mil
2006	15.3 mil	16.2 mil
2007		10.4 mil*
2008		11.4 mil
2009		12.4 mil

* Reduction in FY07 due to the MMA

7d. Provide a customer satisfaction measure, if available.

NEW DECISION ITEM

RANK: 7

Department: Social Services
Division: Medical Services
DI Name: Replace Life Science Trust Fund

Budget Unit: 90541C

DI#: 1886032

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	38,500,000			38,500,000
TRF				
Total	38,500,000			38,500,000

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	38,500,000			38,500,000
TRF				
Total	38,500,000			38,500,000

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input checked="" type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

The General Assembly appropriated \$38,500,000 from the Life Sciences Research Trust Fund to fund pharmaceutical payments under the Medicaid fee-for-service. It is anticipated that all of the \$38,500,000 will not be available. The request is to replace the \$38,500,000 funded from the Life Sciences Research Trust Fund with General Revenue to ensure the pharmacy program is adequately funded for projected expenditures.

The state authority for the pharmacy program is RSMo. 208.152, 208.166, and the federal authority is Social Security Act Section 1902(a)(12), and 42 CFR 440.120

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

It is anticipated that \$38,500,000 from the Life Sciences Trust Fund will not be available in FY 08. General Revenue is requested to replace this shortfall.

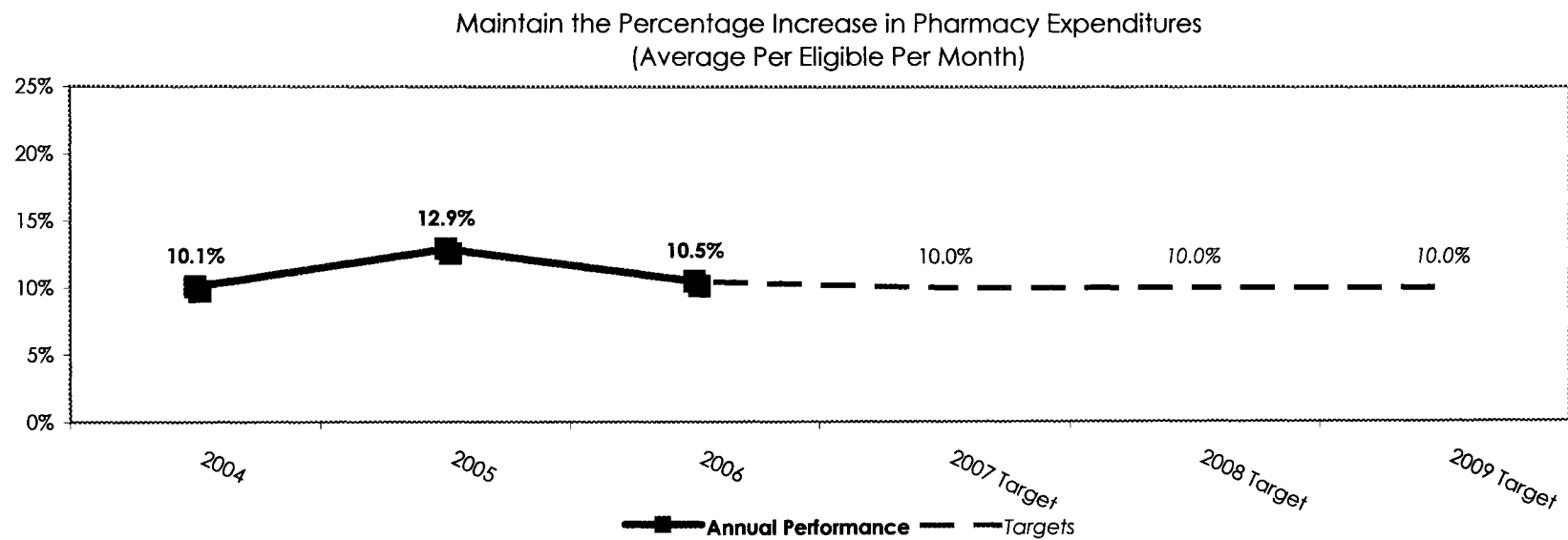
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	38,500,000						38,500,000		
Total PSD	38,500,000		0		0		38,500,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	38,500,000	0.0	0	0.0	0	0.0	38,500,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	38,500,000						38,500,000		
Total PSD	38,500,000		0		0		38,500,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	38,500,000	0.0	0	0.0	0	0.0	38,500,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.



6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY								
Replace Life Science Trust Fun - 1886032								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	38,500,000	0.00	38,500,000	0.00
TOTAL - PD	0	0.00	0	0.00	38,500,000	0.00	38,500,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$38,500,000	0.00	\$38,500,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$38,500,000	0.00	\$38,500,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
PHARMACY-MED PART D-CLAWBACK									
CORE									
EXPENSE & EQUIPMENT									
GENERAL REVENUE	243,750	0.00	0	0.00	0	0.00	0	0.00	
TOTAL - EE	243,750	0.00	0	0.00	0	0.00	0	0.00	
PROGRAM-SPECIFIC									
GENERAL REVENUE	87,385,170	0.00	184,800,000	0.00	184,800,000	0.00	184,800,000	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	310,473,609	0.00	1	0.00	1	0.00	
TOTAL - PD	87,385,170	0.00	495,273,609	0.00	184,800,001	0.00	184,800,001	0.00	
TOTAL	87,628,920	0.00	495,273,609	0.00	184,800,001	0.00	184,800,001	0.00	
Clawback Rate Increase - 1886036									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	11,469,134	0.00	11,469,134	0.00	
TOTAL - PD	0	0.00	0	0.00	11,469,134	0.00	11,469,134	0.00	
TOTAL	0	0.00	0	0.00	11,469,134	0.00	11,469,134	0.00	
GRAND TOTAL	\$87,628,920	0.00	\$495,273,609	0.00	\$196,269,135	0.00	\$196,269,135	0.00	

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Pharmacy--Medicare Part D Clawback

Budget Unit: 90543C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE					EE				
PSD	184,800,000	1		184,800,001	PSD	184,800,000	1		184,800,001 E
TRF					TRF				
Total	184,800,000	1		184,800,001	Total	184,800,000	1		184,800,001 E
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

Other Funds:

Notes: An "E" is requested for the \$1 Federal Funds.

Notes: An "E" is requested for the \$1 Federal Funds.

2. CORE DESCRIPTION

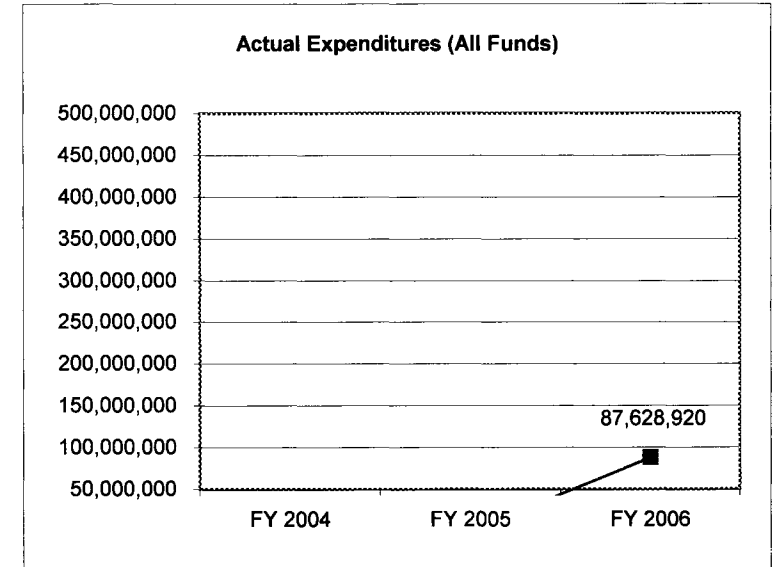
Part of the Medicare Prescription Drug Act requires States to pay Medicare a portion of the cost of Part D drugs attributable to what would have been paid for by the State absent the Part D drug benefit. Beginning January 2006, the State is responsible to pay Medicare 90% of an average per person drug cost for each of the State's full-benefit dual eligibles for each month.

3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy--Medicare Part D--Clawback

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	0	0	316,865,339	495,273,609
Less Reverted (All Funds)	0	0	(9,771,250)	N/A
Budget Authority (All Funds)	0	0	307,094,089	N/A
Actual Expenditures (All Funds)	0	0	87,628,920	N/A
Unexpended (All Funds)	0	0	219,465,169	N/A
Unexpended, by Fund:				
General Revenue	0	0	7,343	N/A
Federal	0	0	189,457,826	N/A
Other	0	0	30,000,000	N/A
	(1)	(1)	(2)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) This is a new appropriation. Prior to Medicare Part D, pharmacy costs for the dual eligibles would have been paid from the Pharmacy appropriation.

(2) Agency reserve of \$189,457,826 in Federal Funds and \$30,000,000 in MO Rx Plan Fund.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES PHARMACY-MED PART D-CLAWBACK

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES								
	PD		0.00	184,800,000	310,473,609	0	495,273,609	
	Total		0.00	184,800,000	310,473,609	0	495,273,609	
DEPARTMENT CORE ADJUSTMENTS								
Core Reduction	1671 7239	PD	0.00	0	(310,473,608)	0	(310,473,608)	Core Cut authority from Medicaid to Medicare Transition
NET DEPARTMENT CHANGES			0.00	0	(310,473,608)	0	(310,473,608)	
DEPARTMENT CORE REQUEST								
	PD		0.00	184,800,000	1	0	184,800,001	
	Total		0.00	184,800,000	1	0	184,800,001	
GOVERNOR'S RECOMMENDED CORE								
	PD		0.00	184,800,000	1	0	184,800,001	
	Total		0.00	184,800,000	1	0	184,800,001	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY-MED PART D-CLAWBACK								
CORE								
PROFESSIONAL SERVICES	243,750	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	243,750	0.00	0	0.00	0	0.00	0	0.00
PROGRAM DISTRIBUTIONS	87,385,170	0.00	495,273,609	0.00	184,800,001	0.00	184,800,001	0.00
TOTAL - PD	87,385,170	0.00	495,273,609	0.00	184,800,001	0.00	184,800,001	0.00
GRAND TOTAL	\$87,628,920	0.00	\$495,273,609	0.00	\$184,800,001	0.00	\$184,800,001	0.00
GENERAL REVENUE	\$87,628,920	0.00	\$184,800,000	0.00	\$184,800,000	0.00	\$184,800,000	0.00
FEDERAL FUNDS	\$0	0.00	\$310,473,609	0.00	\$1	0.00	\$1	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Pharmacy--Medicare Part D Clawback

Program is found in the following core budget(s): Pharmacy--Medicare Part D Clawback

1. What does this program do?

PROGRAM SYNOPSIS: This was a new section requested in FY 06. The funding is a transfer from the Pharmacy section for "clawback" payments to the federal government.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires that all individuals who are eligible for both Medicare and Medicaid begin receiving their prescription drugs through the Medicare Part D program. This change will result in a significant shift in benefits for elderly and disabled dual eligible beneficiaries because they will receive their drugs through a prescription drug plan (PDP) rather than through the state Medicaid program.

Beginning in January 2006, states are required to make a monthly payment to the federal government to, in effect, re-direct the money that the states would have spent on providing prescription drugs to beneficiaries in Medicaid. The clawback will consist of a monthly calculation based on the combination of (a) the state's per capita spending on prescription drugs in 2003, (b) the state Medicaid matching rate, (c) the number of dual eligibles residing in the state, and (d) a "phase-down percentage" of state savings to be returned to the federal government, beginning with 90 percent in 2006 and phasing down to 75 percent in 2015.

The federal government refers to this payment as the "Phased-down State Contribution", whereas the States more appropriately refer to the payment as the "Clawback". This clawback payment is, in effect, a funding source for the Medicare Part D program. In theory, it uses the General Revenue that the State would have paid for the Medicaid pharmacy benefit for funding the Part D program.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003

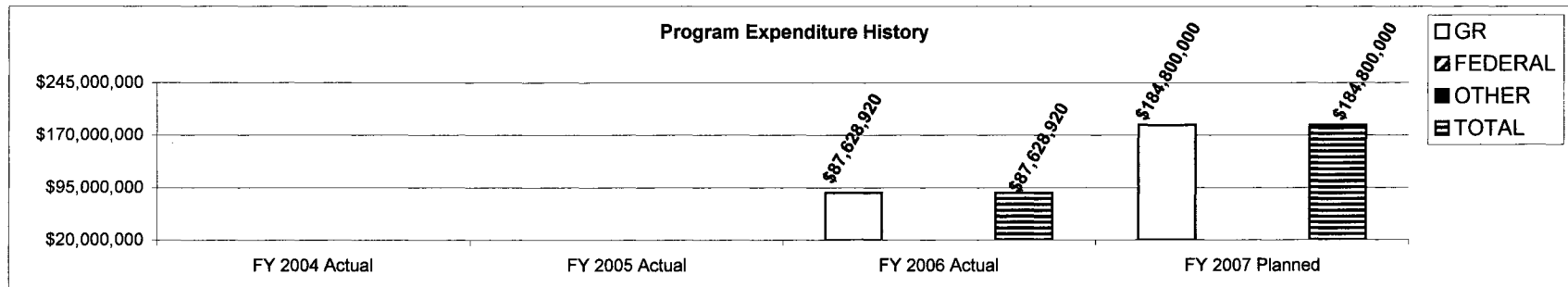
3. Are there federal matching requirements? If yes, please explain.

No.

4. Is this a federally mandated program? If yes, please explain.

Yes, the states are required to make a monthly payment to the federal government to re-direct the money that the states would have spent on providing prescription drugs to beneficiaries in Medicaid.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



Program began January 2006.

6. What are the sources of the "Other " funds?

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Number of Clients Served		
SFY	Actual	Projected
2006	124,301	
2007		130,000
2008		139,200
2009		140,000

7d. Provide a customer satisfaction measure, if available.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	11,469,134						11,469,134		
Total PSD	11,469,134		0		0		11,469,134		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	11,469,134	0.0	0	0.0	0	0.0	11,469,134	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	11,469,134						11,469,134		
Total PSD	11,469,134		0		0		11,469,134		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	11,469,134	0.0	0	0.0	0	0.0	11,469,134	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

**NEW DECISION ITEM
RANK: 17**

Department: Social Services
Division: Medical Services
DI Name: Clawback Rate Increase

Budget Unit: 90543C
DI#: 1886036

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	11,469,134			11,469,134
TRF				
Total	11,469,134			11,469,134
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	11,469,134			11,469,134
TRF				
Total	11,469,134			11,469,134
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

This funding is requested for the anticipated increase in dual eligibles and the anticipated increase in the Clawback assessment.

This decision item requests funding for the increase in GR needed for the payment of the Clawback, as calculated by CMS.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

Calculation for the Medicare Clawback payment is shown below.

	Jan 07 - Sept 07	Oct 07 - Dec 07	Jan 08 - Sept 08	
2006 Per Capita Drug Cost	\$338.02	\$338.02	\$388.72	15% trend
SMAP	38.40%	37.58%	37.58%	
State Per Capita Drug Cost	\$129.79	\$127.03	\$146.08	
PhaseDown Percent	88.33%	88.33%	86.67%	
Assessment	\$114.65	\$112.21	\$126.61	
Duals	136,000	136,000	139,200	
SFY08 Months @ Rate	4	3	5	
Cost	\$62,368,176	\$45,780,844	\$88,120,114	
Need	(\$196,269,134)			
Clawback Core	\$184,800,000			
Request	(\$11,469,134)			

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHARMACY-MED PART D-CLAWBACK								
Clawback Rate Increase - 1886036								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	11,469,134	0.00	11,469,134	0.00
TOTAL - PD	0	0.00	0	0.00	11,469,134	0.00	11,469,134	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$11,469,134	0.00	\$11,469,134	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$11,469,134	0.00	\$11,469,134	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MISSOURI RX PLAN								
CORE								
PROGRAM-SPECIFIC								
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	13,820,394	0.00	13,820,394	0.00
MISSOURI RX PLAN FUND	2,405,654	0.00	19,602,166	0.00	5,781,772	0.00	5,781,772	0.00
TOTAL - PD	2,405,654	0.00	19,602,166	0.00	19,602,166	0.00	19,602,166	0.00
TOTAL	2,405,654	0.00	19,602,166	0.00	19,602,166	0.00	19,602,166	0.00
Missouri Rx Commission - 1886064								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	350,000	0.00
TOTAL - EE	0	0.00	0	0.00	0	0.00	350,000	0.00
TOTAL	0	0.00	0	0.00	0	0.00	350,000	0.00
GRAND TOTAL	\$2,405,654	0.00	\$19,602,166	0.00	\$19,602,166	0.00	\$19,952,166	0.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Missouri Rx Plan

Budget Unit: 90538C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE					EE				
PSD			19,602,166	19,602,166	PSD			19,602,166	19,602,166
TRF					TRF				
Total			19,602,166	19,602,166	Total			19,602,166	19,602,166
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Missouri Rx Plan Fund (0779)
Healthy Families Trust (0625)

Notes: An "E" is requested for the Missouri Rx Plan Fund

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Missouri Rx Plan Fund (0779)
Healthy Families Trust (0625)

Notes: An "E" is requested for the Missouri Rx Plan Fund

2. CORE DESCRIPTION

The Missouri Rx Plan will provide certain pharmaceutical benefits to certain low-income elderly and disabled residents of the state, facilitate coordination of benefits between the Missouri Rx plan and the federal Medicare Part D drug benefit program established by the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173 and enroll individuals in the program.

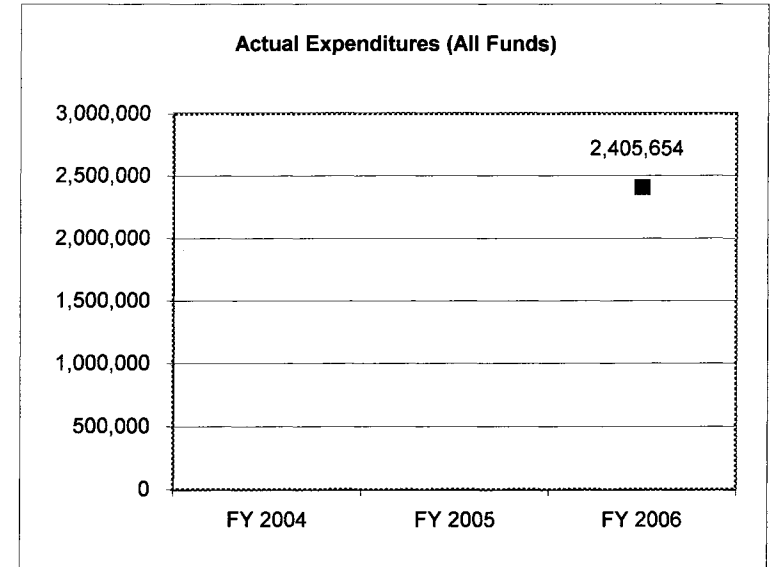
3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy services under MMA - Part D

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.	
Appropriation (All Funds)	0	0	2,405,660	19,602,166	E
Less Reverted (All Funds)	0	0	0	N/A	
Budget Authority (All Funds)	0	0	2,405,660	N/A	
Actual Expenditures (All Funds)			2,405,654	N/A	
Unexpended (All Funds)	0	0	6	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	0	N/A	
Other	0	0	6	N/A	

(1)



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriation for Missouri RX Plan Fund for FY 06 and FY 07.

(1) Legislation (SB 539) allows for the transfer of any unexpended and unobligated funds of the Missouri Senior Rx Fund to the Missouri Rx Plan Fund in FY 06.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

MISSOURI RX PLAN

5. CORE RECONCILIATION DETAIL

				Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES										
				PD	0.00	0	0	19,602,166	19,602,166	
				Total	0.00	0	0	19,602,166	19,602,166	
DEPARTMENT CORE ADJUSTMENTS										
Core Reallocation	2111	3705	PD		0.00	0	0	13,820,394	13,820,394	Reallocation from #0779 to #0625
Core Reallocation	2111	1024	PD		0.00	0	0	(13,820,394)	(13,820,394)	Reallocation from #0779 to #0625
NET DEPARTMENT CHANGES					0.00	0	0	0	0	
DEPARTMENT CORE REQUEST										
				PD	0.00	0	0	19,602,166	19,602,166	
				Total	0.00	0	0	19,602,166	19,602,166	
GOVERNOR'S RECOMMENDED CORE										
				PD	0.00	0	0	19,602,166	19,602,166	
				Total	0.00	0	0	19,602,166	19,602,166	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MISSOURI RX PLAN								
CORE								
PROGRAM DISTRIBUTIONS	2,405,654	0.00	19,602,166	0.00	19,602,166	0.00	19,602,166	0.00
TOTAL - PD	2,405,654	0.00	19,602,166	0.00	19,602,166	0.00	19,602,166	0.00
GRAND TOTAL	\$2,405,654	0.00	\$19,602,166	0.00	\$19,602,166	0.00	\$19,602,166	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$2,405,654	0.00	\$19,602,166	0.00	\$19,602,166	0.00	\$19,602,166	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Missouri Rx Plan

Program is found in the following core budget(s): Missouri Rx Plan

1. What does this program do?

PROGRAM SYNOPSIS: Pharmacy benefit program for Medicare/Medicaid dual eligibles and certain elderly and disabled below 200% of Federal Poverty Level (FPL), which provides a wrap around benefit for those enrolled in Medicare's (Part D) prescription drug program.

S.B. 539 (2005) established a state pharmaceutical assistance program known as the Missouri Rx Plan. The purpose of this program is to coordinate pharmaceutical benefits between the Missouri Rx plan and the federal Medicare Part D drug program for Medicare/Medicaid dual eligibles and other elderly and disabled Missourians below 200% of FPL. The Missouri Rx plan pays for 50% of members' out of pocket costs remaining after their Medicare Prescription Drug Plan pays. Missouri Rx pays for 50% of the deductible, 50% of the co-pays before the coverage gap, 50% of the coverage gap, and 50% of the co-pays in the catastrophic coverage.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State: RSMo. 208.780 through 208.798; Federal law: Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173.

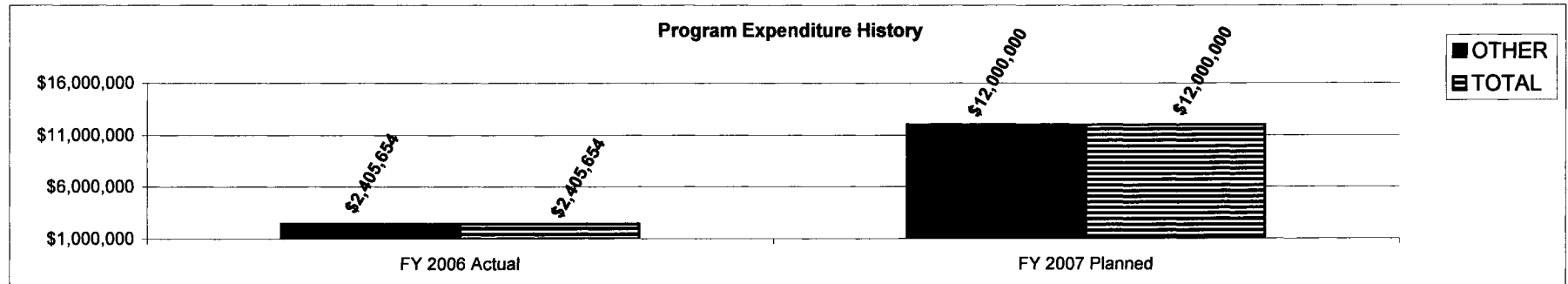
3. Are there federal matching requirements? If yes, please explain.

No. This program is funded with 100% state sources.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



New program January 2006.

6. What are the sources of the "Other " funds?

Missouri Rx Plan Fund (1024)

7a. Provide an effectiveness measure.**7b. Provide an efficiency measure.****7c. Provide the number of clients/individuals served, if applicable.**

In FY2006, the Missouri Rx Program was available to all Medicare/Medicaid dual eligibles and former Senior Rx members enrolled in a Medicare Part D Prescription Drug Program. In FY2007, the program was expanded to include individuals enrolled in a Medicare Part D Prescription Drug Program who are below 200% of Federal Poverty Level (FPL).

Average Monthly MoRx Users		
SFY	Actual	Projected
2006	155,000	
2007		161,500
2008		161,500
2009		161,500

Number of MoRx Claims		
SFY	Actual	Projected
2006	1.54 mil*	
2007		6.16 mil
2008		8.21 mil
2009		8.21 mil

*New program January 2006

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: Missouri Rx Commission

Budget Unit Number: 90538C
DI#: 1886064

1. AMOUNT OF REQUEST

FY 2007 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

FY 2007 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE	350,000			350,000
PSD				
TRF				
Total	350,000			350,000
FTE	0.00			0.00

Est. Fringe				
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Supplemental
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to support expense and equipment for the Missouri Rx Plan Advisory Commission.

Funding is being requested for support of the Missouri Rx Plan Advisory Commission. The advisory commission is charged with providing advice on the benefit design and operational policy of the Missouri Rx Plan.

State statute: RSMo. 208.792

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The funding of \$350,000 is requested to provide support for the Missouri Rx Plan Advisory Commission and to establish a clearinghouse to educate Missouri residents on quality prescription drug programs and to assist Missouri residents in enrolling or accessing prescription drug assistance programs for which they are eligible. These funds are requested from general revenue. With the transition of the Missouri Senior Rx Program in the Department of Health and Senior Services to the Missouri Rx Plan, the advisory commission is being created within the Department of Social Services where the Missouri Rx Plan is being administered. The commission is being established pursuant to SB 539 (2005).

	GR	Fed	Other	Total
Expense & Equipment	350,000			350,000
	350,000			350,000

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0	0.0	0
Total PSD	0		0		0		0	0.0	0
Total Transfers	0	0.0	0	0.0	0	0.0	0	0.0	0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

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5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Professional Services	350,000						350,000		
Total EE	350,000		0		0		350,000		0
Total PSD	0		0		0		0		0
Total Transfers	0	0.0	0	0.0	0	0.0	0	0.0	0
Grand Total	350,000	0.0	0	0.0	0	0.0	350,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Number of Senior Rx Program participants		
SFY	Actual	Projected
FY 2003	21,928	
FY 2004	18,797	
FY 2005	17,438	
FY 2006	13,787	

Projected number of Missouri Rx Plan participants		
SFY	Actual	Projected
FY 2006	155,000	
FY 2007		161,500
FY 2008		161,500
FY 2009		161,500

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Provide advice on guidelines, policies and procedures necessary to establish the Missouri Rx Plan
- Educate Missouri residents on quality prescription drug programs and cost containment strategies in medication therapy
- Assist Missouri residents in enrolling or accessing prescription drug assistance programs for which they are eligible
- Hold quarterly meetings and other meetings as deemed necessary to meet Missouri Rx Plan objectives

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MISSOURI RX PLAN								
Missouri Rx Commission - 1886064								
PROFESSIONAL SERVICES	0	0.00	0	0.00	0	0.00	350,000	0.00
TOTAL - EE	0	0.00	0	0.00	0	0.00	350,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$350,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$350,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Pay for Performance - 1886056								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	1,100,000	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	1,811,593	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,911,593	0.00
TOTAL	0	0.00	0	0.00	0	0.00	2,911,593	0.00
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	1,612,552	0.00	1,178,449	0.00	954,599	0.00	954,599	0.00
TITLE XIX-FEDERAL AND OTHER	1,617,628	0.00	1,821,551	0.00	1,050,000	0.00	1,050,000	0.00
TOTAL - EE	3,230,180	0.00	3,000,000	0.00	2,004,599	0.00	2,004,599	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	134,754,357	0.00	150,346,558	0.00	146,153,266	0.00	146,153,266	0.00
TITLE XIX-FEDERAL AND OTHER	236,888,679	0.00	263,741,758	0.00	263,610,260	0.00	263,610,260	0.00
THIRD PARTY LIABILITY COLLECT	1,770,976	0.00	1,906,107	0.00	1,906,107	0.00	1,906,107	0.00
HEALTH INITIATIVES	1,210,118	0.00	1,247,544	0.00	1,247,544	0.00	1,247,544	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	1,041,034	0.00	1,041,034	0.00
HFT-HEALTH CARE ACCT	1,041,034	0.00	1,041,034	0.00	0	0.00	0	0.00
TOTAL - PD	375,665,164	0.00	418,283,001	0.00	413,958,211	0.00	413,958,211	0.00
TOTAL	378,895,344	0.00	421,283,001	0.00	415,962,810	0.00	415,962,810	0.00
Medicaid Caseload Growth - 1886033								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	614,179	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,011,492	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,625,671	0.00	0	0.00
TOTAL	0	0.00	0	0.00	1,625,671	0.00	0	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								

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FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,868,810	0.00	3,868,810	0.00
TOTAL - PD	0	0.00	0	0.00	3,868,810	0.00	3,868,810	0.00
TOTAL	0	0.00	0	0.00	3,868,810	0.00	3,868,810	0.00
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	287,491	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	473,470	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	760,961	0.00
TOTAL	0	0.00	0	0.00	0	0.00	760,961	0.00
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	11,443,972	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	18,847,112	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	30,291,084	0.00
TOTAL	0	0.00	0	0.00	0	0.00	30,291,084	0.00
Health Risk Appraisals - 1886060								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	11,067,515	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	18,227,125	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	29,294,640	0.00
TOTAL	0	0.00	0	0.00	0	0.00	29,294,640	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	583,030	0.00

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FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	960,193	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	1,543,223	0.00
TOTAL	0	0.00	0	0.00	0	0.00	1,543,223	0.00
GRAND TOTAL	\$378,895,344	0.00	\$421,283,001	0.00	\$421,457,291	0.00	\$484,633,121	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Physicians

Budget Unit: 90544C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	954,599	1,050,000		2,004,599
PSD	146,153,266	263,610,260	4,194,685	413,958,211
TRF				
Total	147,107,865	264,660,260	4,194,685	415,962,810

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Third Party Liability Collections Fund (TPL) (0120)
Health Initiatives Fund (HIF) (0275)
Healthy Families Trust Fund (0625)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	954,599	1,050,000		2,004,599
PSD	146,153,266	263,610,260	4,194,685	413,958,211
TRF				
Total	147,107,865	264,660,260	4,194,685	415,962,810

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Third Party Liability Collections Fund (TPL) (0120)
Health Initiatives Fund (HIF) (0275)
Healthy Families Trust Fund (0625)

2. CORE DESCRIPTION

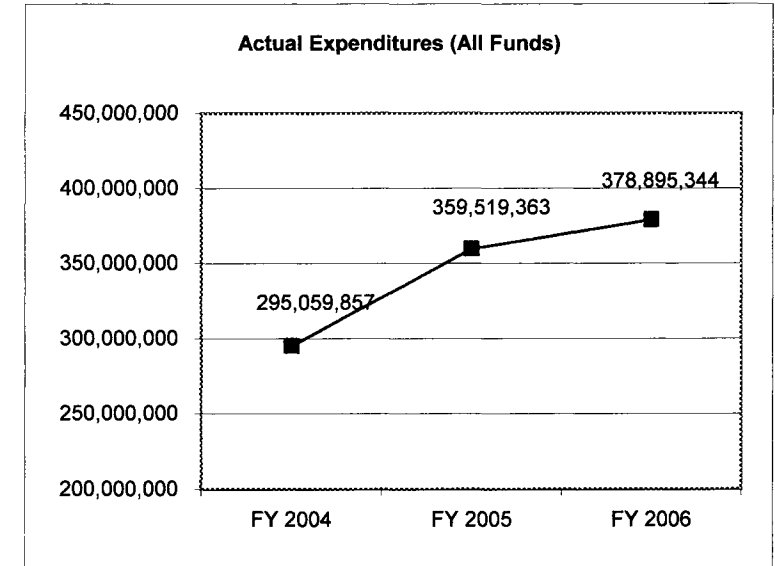
This core request is for the ongoing funding for payments for physician-related services.

3. PROGRAM LISTING (list programs included in this core funding)

Physician-Related Services

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	295,097,283	361,200,768	378,932,890	421,283,001
Less Reverted (All Funds)	(37,426)	(37,426)	(37,426)	N/A
Budget Authority (All Funds)	295,059,857	361,163,342	378,895,464	N/A
Actual Expenditures (All Funds)	295,059,857	359,519,363	378,895,344	N/A
Unexpended (All Funds)	0	1,643,979	120	N/A
Unexpended, by Fund:				
General Revenue	0	2,109	46	N/A
Federal	0	1,870	74	N/A
Other	0	1,640,000	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Expenditures of \$60,051,457 were paid from the Supplemental Pool.

(2) Agency reserve of \$1,640,000 in TPL funds. Expenditures of \$66,614,598 were paid from the Supplemental Pool.

(3) Expenditures of \$27,623,367 were paid from the Supplemental Pool and \$19,091,264 paid from Managed Care.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES PHYSICIANS

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES								
		EE	0.00	1,178,449	1,821,551	0	3,000,000	
		PD	0.00	150,346,558	263,741,758	4,194,685	418,283,001	
		Total	0.00	151,525,007	265,563,309	4,194,685	421,283,001	
DEPARTMENT CORE ADJUSTMENTS								
Core Reduction	1665 8196	PD	0.00	(548,332)	0	0	(548,332)	Core Cut -- MAWD
Core Reduction	1665 8197	PD	0.00	0	(903,049)	0	(903,049)	Core Cut -- MAWD
Core Reduction	1702 8196	PD	0.00	(3,868,810)	0	0	(3,868,810)	FMAP Adjustment
Core Reallocation	1162 8197	EE	0.00	0	(771,551)	0	(771,551)	
Core Reallocation	1162 8196	EE	0.00	(223,850)	0	0	(223,850)	
Core Reallocation	1162 8196	PD	0.00	223,850	0	0	223,850	
Core Reallocation	1162 8197	PD	0.00	0	771,551	0	771,551	
Core Reallocation	2125 5507	PD	0.00	0	0	(1,041,034)	(1,041,034)	Reallocation from #0640 to #0625
Core Reallocation	2125 3707	PD	0.00	0	0	1,041,034	1,041,034	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES			0.00	(4,417,142)	(903,049)	0	(5,320,191)	
DEPARTMENT CORE REQUEST								
		EE	0.00	954,599	1,050,000	0	2,004,599	
		PD	0.00	146,153,266	263,610,260	4,194,685	413,958,211	
		Total	0.00	147,107,865	264,660,260	4,194,685	415,962,810	
GOVERNOR'S RECOMMENDED CORE								
		EE	0.00	954,599	1,050,000	0	2,004,599	

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

PHYSICIANS

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
GOVERNOR'S RECOMMENDED CORE							
	PD	0.00	146,153,266	263,610,260	4,194,685	413,958,211	
	Total	0.00	147,107,865	264,660,260	4,194,685	415,962,810	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
CORE								
PROFESSIONAL SERVICES	3,230,180	0.00	3,000,000	0.00	2,004,599	0.00	2,004,599	0.00
TOTAL - EE	3,230,180	0.00	3,000,000	0.00	2,004,599	0.00	2,004,599	0.00
PROGRAM DISTRIBUTIONS	375,665,164	0.00	418,283,001	0.00	413,958,211	0.00	413,958,211	0.00
TOTAL - PD	375,665,164	0.00	418,283,001	0.00	413,958,211	0.00	413,958,211	0.00
GRAND TOTAL	\$378,895,344	0.00	\$421,283,001	0.00	\$415,962,810	0.00	\$415,962,810	0.00
GENERAL REVENUE	\$136,366,909	0.00	\$151,525,007	0.00	\$147,107,865	0.00	\$147,107,865	0.00
FEDERAL FUNDS	\$238,506,307	0.00	\$265,563,309	0.00	\$264,660,260	0.00	\$264,660,260	0.00
OTHER FUNDS	\$4,022,128	0.00	\$4,194,685	0.00	\$4,194,685	0.00	\$4,194,685	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Physicians

Program is found in the following core budget(s): Physicians

1. What does this program do?

PROGRAM SYNOPSIS: Payment for services provided to fee for service Medicaid/MC+ recipients for physicians/psychologists, clinics, lab & x-ray, nurse midwife, podiatry, certified registered nurse anesthetist, independent diagnostic testing facility, rural health clinic, nurse practitioner and federally qualified health centers.

A general description of each of the Medicaid provider groups included in the Physician section follows:

Physician - Proper health care is essential to the general health and well-being of Title XIX recipients. Physicians, Doctors of Medicine (M.D.'s) and Doctors of Osteopathy (D.O.'s), are typically the front line providers where Medicaid clients enter the state's health care system. They provide a myriad of health care services and tie the various parts of the health care system together.

Physician services are those diagnostic, therapeutic, rehabilitative or palliative procedures provided by, and under the supervision of, a licensed physician who is practicing within the scope of practice allowed and is enrolled in the Missouri Medicaid program.

Physicians enrolled in the Missouri Medicaid program are identified in regards to the specialty of medicine they practice. Specialities include allergy immunology, anesthesiology, dermatology, emergency medicine, family practice, general practice, general surgery, internal medicine, laryngology, nuclear medicine, neurological surgery, obstetrics/gynecology, ophthalmology, otology, otolaryngology, orthopedic surgery, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preventive medicine, proctology, psychiatry, neurology, radiation therapy, radiology, rectal and colon surgery, rehabilitative medicine, rhinology, thoracic surgery, urology and cardiology.

The Early Periodic Screening Diagnosis Treatment /Healthy Children and Youth (EPSDT/HCY) program provides services to non-MC+ managed care eligibles who are infant, children, and youth under the age of 21 years with a primary and preventive care focus. Full, partial and interperiodic health screenings, medical and dental examinations, immunizations and medically necessary treatment services are covered. The goal of the Missouri Medicaid program is for each child to be healthy. This is achieved by the primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child's primary health care needs. The purpose of the EPSDT/HCY program is to insure a comprehensive, preventive health care program for Medicaid eligible children who are under the age of 21 years. The program provides early and periodic medical/dental screening, diagnosis, and treatment to correct or improve defects and chronic conditions found during the screening.

An EPSDT/HCY screening consists of a health and developmental history, unclothed physical examination, developmental assessment, immunization status including any needed immunizations, nutritional status, vision testing, hearing testing, laboratory procedures, dental status, anticipatory guidance, lead level screens (0-6 years), and referrals for follow-up care or evaluation of any abnormality detected. The full screen may be provided by a Medicaid participating: 1) physician or nurse practitioner including nurse midwives under their scope of practice or; 2) clinic or screening provider when the provider of the unclothed physical component of the screen is a physician or nurse practitioner. The periodicity schedule for EPSDT/HCY screening services is as follows:

Newborn (2-3 days); By one month; 2-3 months; 4-5 months; 6-8 months; 9-11 months; 12-14 months; 15-17 months; 18-23 months; 24 months; 3 years; 4 years; 5 years; 6-7 years; 8-9 years; 10-11 years; 12-13 years; 14-15 years; 16-17 years; 18-19 years; 20 years.

The services of a physician may be administered in a myriad of settings including the physician's office, the recipients home (or other place of residence such as a nursing facility), the hospital (inpatient/outpatient) or settings such as a medical clinic or ambulatory surgical care facility.

Services rendered by a physician, including appropriate supplies, are billable by the physician only where there is direct personal supervision by the physician. This applies to services rendered by auxiliary personnel employed by the physician and working under his on-site supervision such as nurses, non-physician anesthetists, technicians, therapists and other aides.

The majority of services provided by a physician are reimbursed on a fee schedule basis although a few services are reimbursed on a manual basis, whereby each procedure/claim is priced individually by a medical consultant based on the unique circumstances of the case. Certain procedures, such as organ transplants, are available only on a prior approval basis.

Psychotherapy is psychology services provided by psychologists for adults who receive services through the fee for service program.

Clinic - Clinics offer preventative, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Services furnished to outpatients include those furnished at the clinic by, or under the direction of, a physician and those services furnished outside the clinic by clinic personnel under the direction of a physician.

Health care givers at a clinic can include physicians, nurse practitioners, radiologists and other health professionals whose services are offered at the clinic.

Medicaid reimbursement is made solely to the clinic. All health care professionals are employed by the clinic. Each provider of health care services through the clinic, in addition to being employed by the participating clinic, must be a Medicaid provider.

Lab & X-Ray - These providers are of two kinds, laboratory facilities and x-ray facilities. Laboratories perform examinations of body fluids, tissues or organs by the use of various methods employing specialized equipment such as electron microscopes and radio-immunoassay. A clinical laboratory is a laboratory where microbiological, serological, chemical, hematological, radio bioassay, cytological, immunohematological or pathological examinations are performed on material derived from the human body to provide information for the diagnosis, prevention or treatment of a disease or assessment of a medical condition. Typically the operations of a laboratory are directed by a pathologist.

X-ray facilities offer radiological services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes. Such services include, but are not limited to radium therapy, the use of radioisotopes for diagnostic or therapeutic purposes (as in nuclear medicine) and diagnostic tests such as aortograms, pyelograms, myelograms, arteriograms and ventriculograms, and imaging services, x-rays, nuclear medicine and diagnostic ultra-sounds. Typically the operations of an x-ray facility are directed by a radiologist.

Both laboratories and x-ray clinics are reimbursed on a fee schedule basis.

Nurse Midwife - Nurse Midwife services are those services related to the management and provision of care to a pregnant woman and her unborn/newborn infant by a non-physician. These services may be provided throughout the maternity cycle which includes pregnancy, labor and delivery and the initial postpartum period not to exceed six weeks. Covered services include antepartum care, delivery, post-partum care, newborn care, office visits, laboratory services and other services within the scope of practice of a nurse midwife. If there is any indication the maternity care is not for a normal uncomplicated delivery, the nurse midwife must refer the case to a physician.

Nurse midwives may also provide care outside of the maternity cycle such as family planning, counseling, birth control techniques and well-woman gynecological care including routine pap smears and breast examinations (Section 13605, OBRA 93). Nurse midwife services may also include services to the newborn, age 0 through 2 months and any other Medicaid eligible female, age 15 and over.

Services furnished by a nurse midwife must be within the scope of practice authorized by federal and state laws or regulations and, in the case of inpatient or outpatient hospital services or clinic services, furnished by or under the direction of a nurse midwife only to the extent permitted by the facility.

In order to qualify for participation in the Missouri Medicaid Nurse Midwife program, in addition to provisions required of all Medicaid providers, the applicant must hold a valid current license as an advanced practice nurse (RN) in the state of Missouri and be currently certified as a Nurse Midwife by the American College of Nurse Midwives.

The services of a nurse midwife may be administered in a variety of settings including the providers' office, a hospital (inpatient or outpatient), the home of the recipient (delivery and newborn care only) or a birthing center. Reimbursement for nurse midwife services made on a fee-for-service basis are determined as follows: the Medicaid maximum allowable fee for any particular procedure has been determined by the Division of Medical Services to be a reasonable fee, consistent with efficiency, economy and quality of care. Medicaid payment for covered services are the lower of the provider's actual billed charge, based on his/her usual and customary charge to the general public for the service, or the Medicaid maximum allowable amount per unit of service. The level of reimbursement to the Nurse Midwife is the same as that reimbursed to a physician for the same procedure.

Podiatry - Podiatrists provide medical, surgical and mechanical services for the foot or any area not above the ankle joint and receive Medicaid reimbursement for diagnostic, therapeutic, rehabilitative and palliative services which are within the scope of practice the podiatrist is authorized to perform. Most services provided by a podiatrist are reimbursed on a fee schedule basis although a few services are reimbursed on a manual basis, whereby each procedure/claim is priced individually by a medical consultant based on the unique circumstances of the case.

The following podiatry services are not covered for Adults (except individuals under a category of assistance for pregnant women or the blind or nursing facility residents): trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s) one to five; debridement of nail(s) by any method(s) six or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and /or foot.

The services of a podiatrist may be administered in a myriad of settings including the podiatrist's office, the recipient's home (or other place of residence such as a nursing facility), the hospital (inpatient/outpatient) or settings such as a medical clinic or ambulatory surgical care facility.

Certified Registered Nurse Anesthetist (CRNA) - CRNA services are those services related to the introduction and management of a substance into the body by external or internal means that causes loss of sensation (feeling) with or without loss of consciousness. In order to qualify for participation in the Missouri Medicaid Certified Registered Nurse Anesthetist program, in addition to provisions required of all Medicaid providers, the applicant must hold a valid current license as an advanced practice nurse (RN), or nurse practitioner, in the state of Missouri and be currently certified as a CRNA by the Council on Certification of Nurse Anesthetists.

Reimbursement for CRNA services are made on a fee-for-service basis. The services of a CRNA may be administered in a variety of settings including the providers' office, a hospital, nursing home or clinic and include the same scope of practice as that of an anesthesiologist. Typically, CRNAs are employed by physicians (anesthesiologists), but are not required to be.

Independent Diagnostic Testing Facility (IDTF) - These providers are independent of a hospital or a physician's office and offer medically necessary diagnostic tests. The IDTF may be a fixed location or a mobile entity. An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of non-physician personnel who use the equipment.

Rural Health Clinic (RHC) - The Rural Health Clinic Services Act of 1977 designated a new health care provider, Rural Health Clinics. The Act became effective for Medicaid reimbursement on July 1, 1978. The Rural Health Clinic Services Act of 1977 extended benefits to cover health care services to under-served rural areas where access to traditional physician care has been difficult. In those areas, specifically trained practitioners furnish the health care services needed by the community.

Rural Health Clinics must be located in a rural area that is designated a shortage area for primary care. To be eligible for this designation, a clinic must be located in an area not identified as "urbanized" by the Bureau of the Census and designated as a shortage or under-served area in one of the following ways:

- ♦ An area with a shortage of personal health services under Section 30(b)(3) or 330(b)(3) of the Public Health Service Act (PHS);
- ♦ As a Health Professional Shortage Area (HPSA) designated under Section 332(a)(1)(A) of the PHS Act;
- ♦ An area which includes a population group designated as having a health professional shortage under Section 332(a)(1)(B) of the PHS Act;
- ♦ An area designated by the chief executive officer (Governor) of the State and certified by the Secretary of Health and Human Services as an area with a shortage of personal health services.

In addition to the above criteria, RHC's must meet the additional Staffing and Health and Safety Requirements set forth by the Rural Health Clinic Services Act. To be a Missouri Medicaid RHC, a clinic must be certified by the Public Health Service, be certified for participation in Medicare and be enrolled as a Medicaid provider. The RHC is then designated as either Independent or Provider-Based.

In order to be designated Provider-Based, an RHC must be an integral and subordinate part of a hospital, skilled nursing facility or home health agency. The Provider-Based RHC must also be under common licensure, governance and professional supervision with its parent provider. Hospital-based RHC's are reimbursed the lower of 100% of their usual and customary charges or their cost-to-charge ratio. The skilled nursing facility and home health agency based RHC's are reimbursed their usual and customary charges multiplied by the lower of the Medicare RHC rate or the rate approved by the Division of Medical Services.

An independent RHC has no financial, organizational or administrative connection to a hospital, skilled nursing facility or home health agency. They are reimbursed the lesser of their reasonable costs divided by total encounter or the Medicare upper payment limit and multiplied by the number of Medicaid encounters. An annual audit of the Medicare cost report is reviewed by the Institutional Reimbursement Unit (IRU) within the Division of Medical Services.

Nurse Practitioner - A nurse practitioner, or advanced practice nurse, is one who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Missouri Board of Nursing. The Board of Nursing may promulgate rules specifying which professional nursing organization certifications are to be recognized as advanced practice nurses and may set standards for education, training and experience required for those without such specialty certification to become advanced practice nurses.

Numerous specialties are recognizable such as family nurse practitioner (NP), gerontology NP, clinical NP, obstetrics/GYN NP, neonatal NP and certified registered nurse anesthetists. Reimbursement for nurse practitioner services are made on a fee-for-service basis. The level of reimbursement to the Nurse Practitioner is the same as that reimbursed to a physician for the same procedure. Nurse practitioners, or advanced practical nurses may prescribe medications only through a collaborative agreement with a physician.

Nurse practitioner services involve the performance for compensation of any act which requires substantial specialized education, judgment, and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including: a) responsibility for the teaching of health care and the prevention of illness to the patient and his family; b) assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes; c) administration of medications and treatments as prescribed by a person licensed in this state to prescribe such medications and treatments; and d) coordination and assistance in the delivery of a plan of health care with all members of the health team.

The services of a nurse practitioner may be administered in a variety of settings including the providers' office, a hospital, nursing home or clinic. Typically, nurse practitioners are employed by physicians, but are not required to be.

Federally Qualified Health Clinic (FQHC) - The Federally Qualified Health Center (FQHC) program was established by the Omnibus Budget Reconciliation Acts of 1989 (OBRA 89) and 1990 (OBRA 90). These laws designated certain community-based health care organizations as unique health care providers called Federally Qualified Health Centers. These laws establish a set of FQHC health care services that Medicaid and Medicare must cover for those beneficiaries who receive services from the FQHC and require the reimbursement of reasonable cost to the FQHC for such services.

By passing the FQHC legislation, Congress recognized two goals of the FQHC program:

- ♦ To provide adequate reimbursement to community-based primary health care organizations (FQHCs) so that they, in turn, may better serve large numbers of Medicaid recipients and/or provide more services, thus improving access to primary care.
- ♦ To enable FQHCs to use other resources previously subsidizing Medicaid to serve uninsured individuals who, although not eligible for Medicaid, have a difficult time obtaining primary care because of economic or geographic barriers.

In order to qualify for FQHC status, a facility must receive or be eligible for a grant under Section 329, 330 or 340 of the Public Health Service Act, meet the requirements for receiving such a grant, or have been a Federally Funded Health Center as of January 1, 1990.

FQHC services are reimbursed on the interim at 97% of billed Medicaid FQHC covered charges. An annual audit of the Medicaid cost report is performed by the Institutional Reimbursement Unit (IRU) to determine reasonable costs. A settlement is made to adjust the reimbursement to 100% of the reasonable costs to provide Medicaid FQHC covered services.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.153, 208.166; Federal law: Social Security Act Sections 1905(a)(2), (3), (5), (6), (9), (17), (21); 1905(r) and 1915(d); Federal regulations: 42 CFR 440.210, 440.500, 412.113(c) and 441 Subpart B.

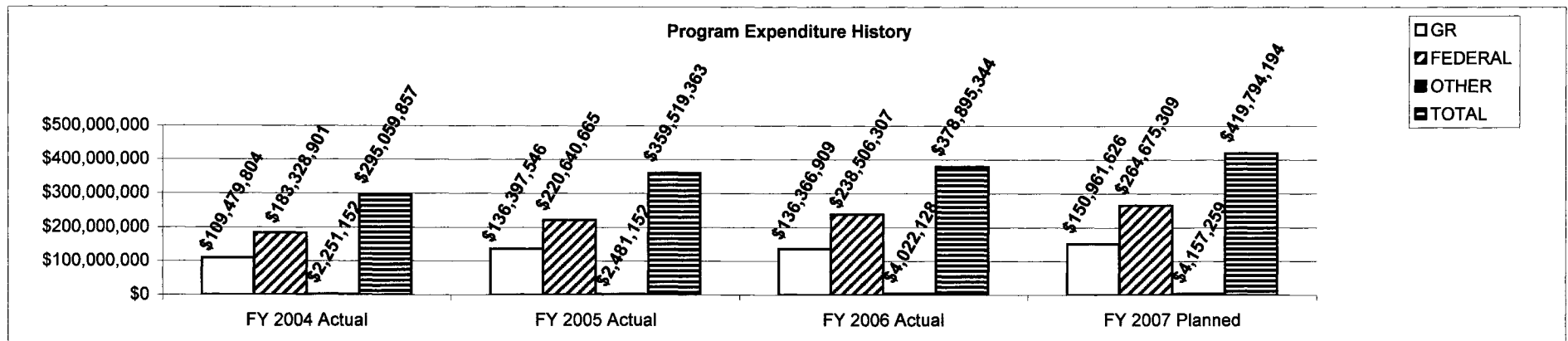
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Yes, if the state elects to have a Medicaid program. (Some services are optional: podiatry, clinics, nurse practitioners and certified nurse anesthetist.)

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

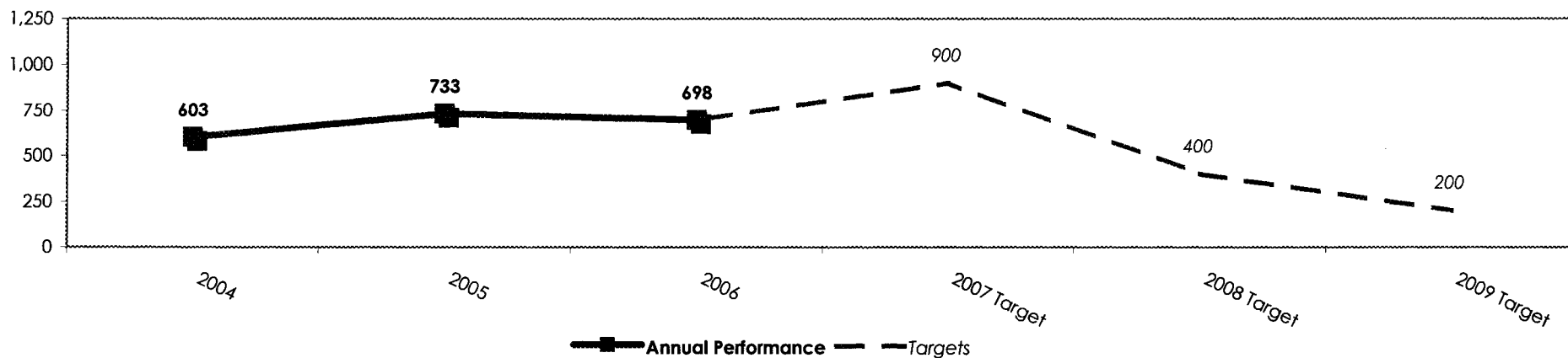


6. What are the sources of the "Other" funds?

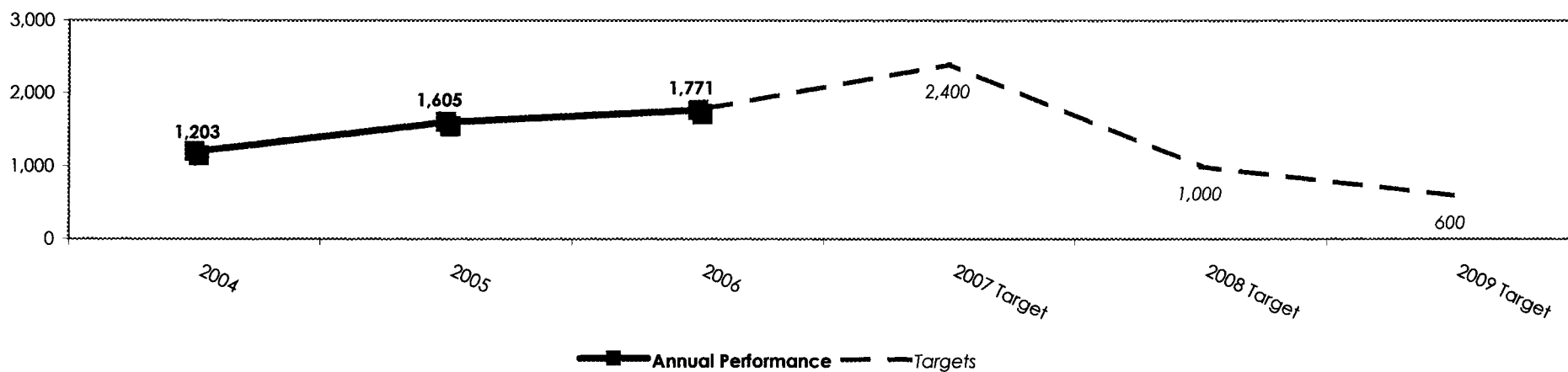
Third Party Liability Collections Fund (0120), Health Initiatives Fund (0275) and Healthy Families Trust Fund-Health Care Account (0640)

7a. Provide an effectiveness measure.

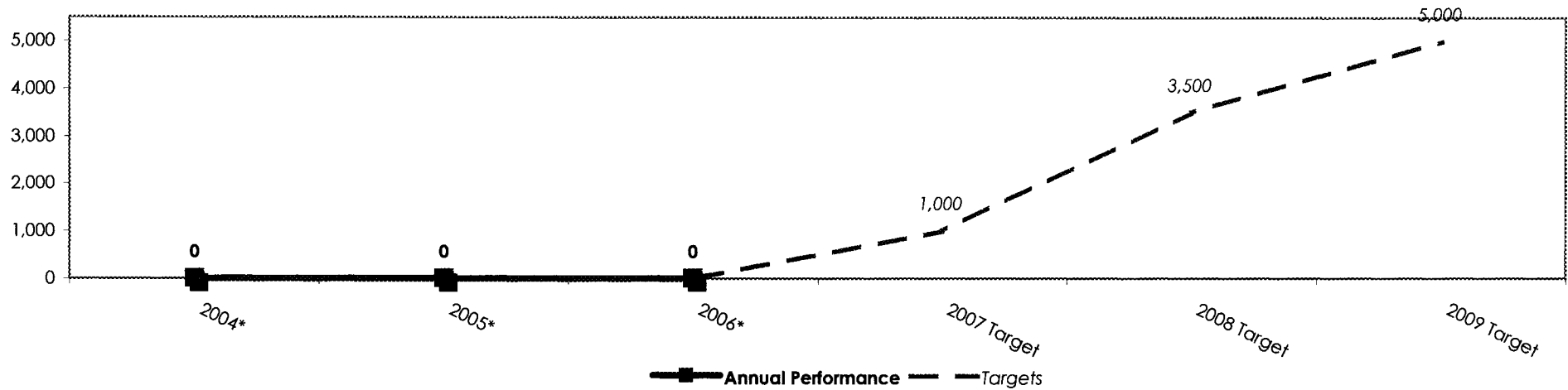
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

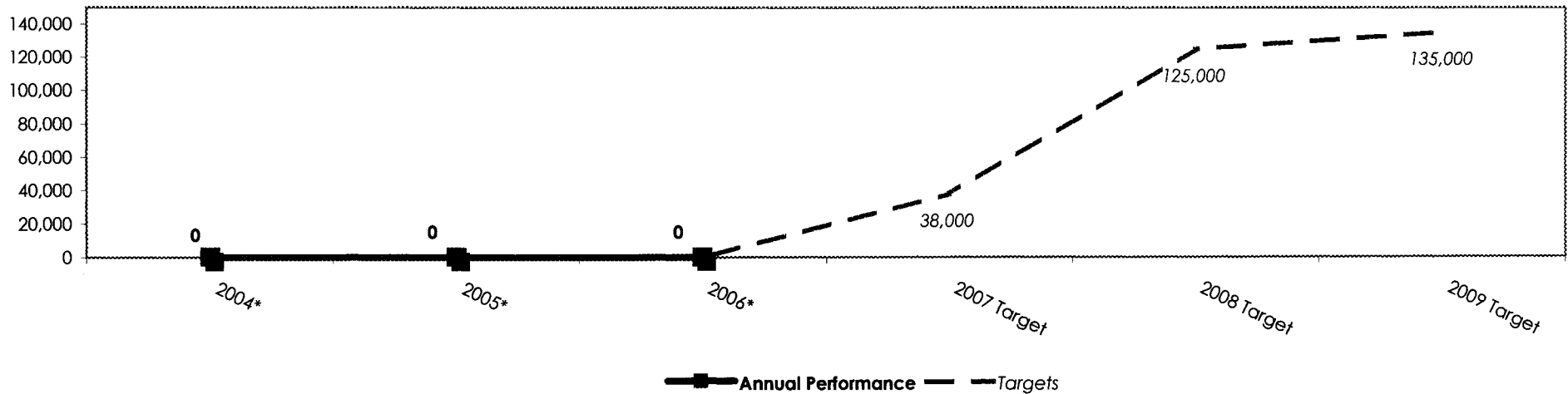


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Physician services are available to fee for service Medicaid/MC+ eligibles. In the regions of the state where MC+ managed care has been implemented, enrollees have physician services available through the MC+ managed care health plan.

Average Monthly Physician Users		
SFY	Actual	Projected
2004	209,756	
2005	232,693	228,424
2006	219,015	233,020
2007		229,966
2008		241,464
2009		253,537

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 0**

Department: Social Services
Division: Medical Services
DI Name: Pay for Performance

Budget Unit: 90544C
DI#: 1886056

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				<u>0</u>
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	1,100,000	1,811,593		2,911,593
TRF				
Total	<u>1,100,000</u>	<u>1,811,593</u>		<u>2,911,593</u>
FTE				0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> X	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/>	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/>	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/>	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to support pay for performance related to Chronic Care Improvement Program (CCIP).

The funding is being requested to support the Pay for Performance (P4P) component of the CCIP program. Pay for performance programs link evidence-based performance measures to financial incentives. P4P rewards providers who follow the treatment protocols and guidelines for the diseases targeted by the CCIP.

Pay for Performance is part of the transformation of Missouri Medicaid to MO HealthNet.

The State Authority is 208.152 and 208.166 RSMo.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

This new decision item includes \$1,100,000 GR and matching federal funds (at 62.22% FMAP) for total funding of \$2,911,593. This funding will help begin the P4P program. The actual cost to implement P4P for all CCIP diseases will depend on physician participation and the incentive structure.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

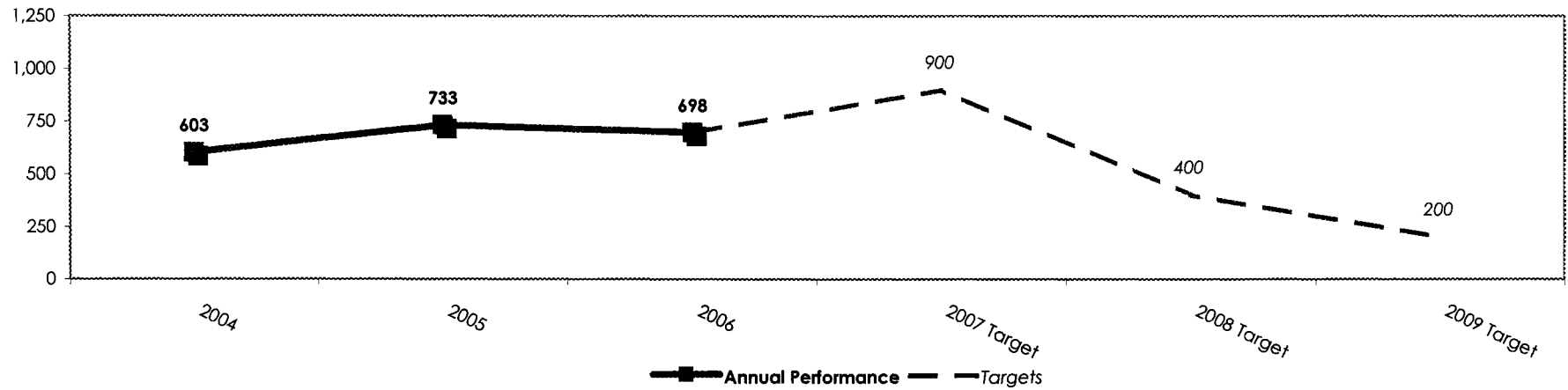
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0	0	0	0	0		0		0
Total PSD	0	0	0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	1,100,000		1,811,593				2,911,593		
Total PSD	1,100,000		1,811,593		0		2,911,593		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	1,100,000	0.0	1,811,593	0.0	0	0.0	2,911,593	0.0	0

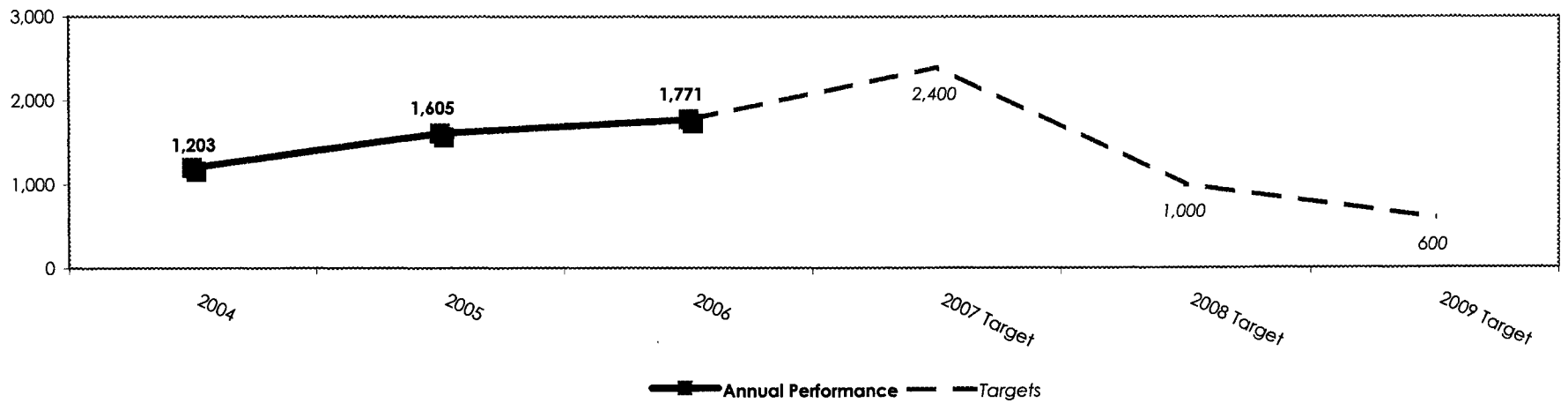
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

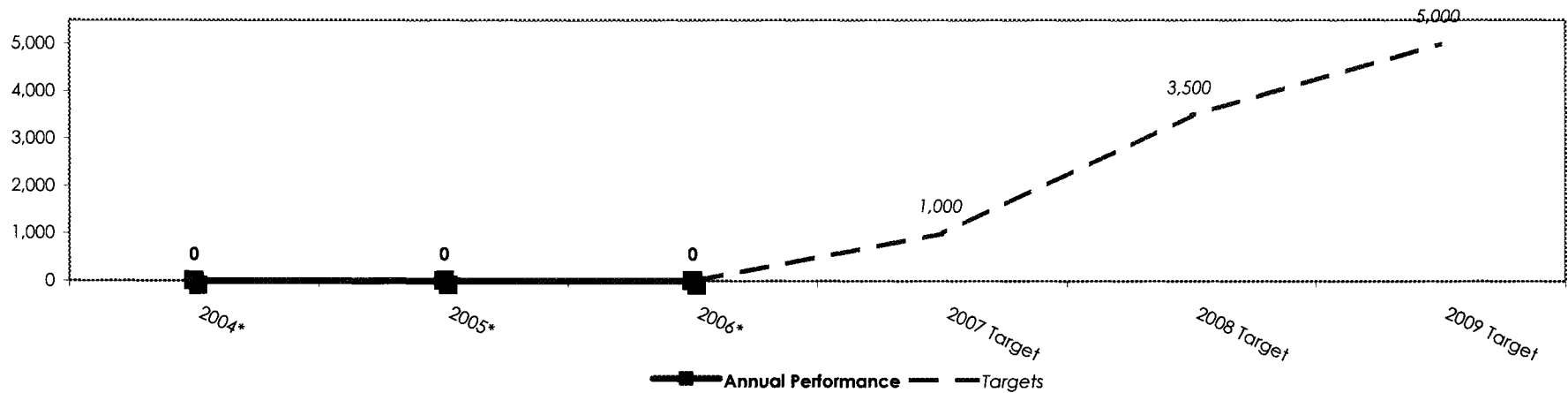
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

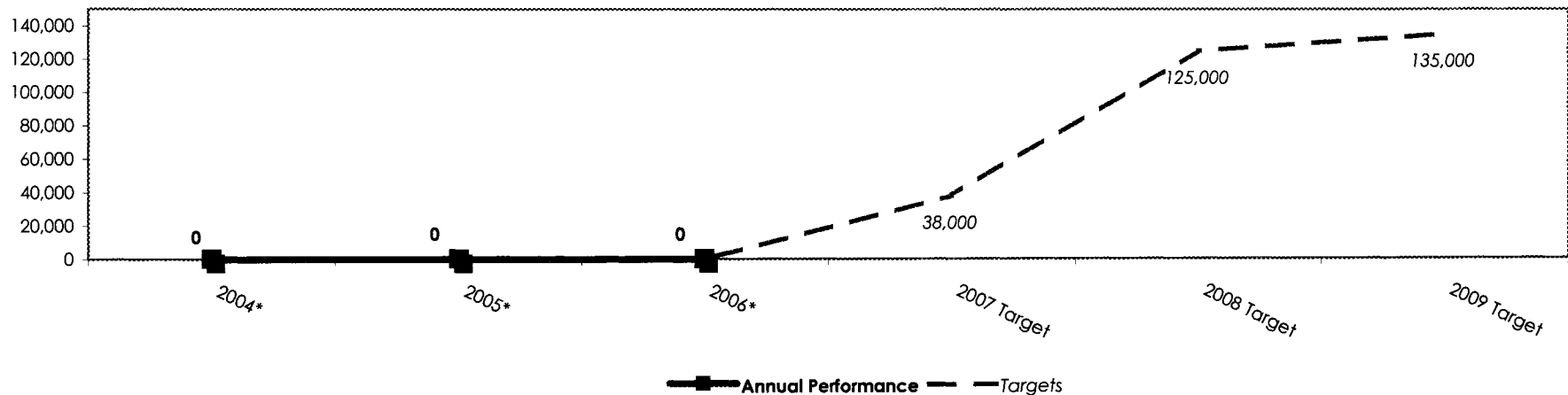


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

SFY	Medicaid Enrollees	
	Actual	Projected
2004	974,559	
2005	992,622	1,005,981
2006	894,220	913,506
2007		828,004
2008		832,561
2009		837,118

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Continue statewide identification of recipients with targeted disease states.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioners.
- Dedicated help desk for recipient support.
- Identify providers currently serving the targeted population to invite them to participate in disease management.
- Continue existing cost containment activities.
- Make personal visits with providers to explain the program and assist with enrollment paperwork.
- Focus on clinical benefits of the participation and show providers the financial incentives.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Dedicated help desk for provider support.

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PHYSICIANS								
Pay for Performance - 1886056								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	2,911,593	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,911,593	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$2,911,593	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$1,100,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$1,811,593	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	2,934,135	0.00	2,658,126	0.00	2,515,506	0.00	2,515,506	0.00
TITLE XIX-FEDERAL AND OTHER	6,355,215	0.00	5,784,920	0.00	5,662,886	0.00	5,662,886	0.00
HEALTH INITIATIVES	69,027	0.00	71,162	0.00	71,162	0.00	71,162	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	848,773	0.00	848,773	0.00
HFT-HEALTH CARE ACCT	848,773	0.00	848,773	0.00	0	0.00	0	0.00
TOTAL - PD	10,207,150	0.00	9,362,981	0.00	9,098,327	0.00	9,098,327	0.00
TOTAL	10,207,150	0.00	9,362,981	0.00	9,098,327	0.00	9,098,327	0.00
Medicaid Caseload Growth - 1886033								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	26,374	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	43,436	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	69,810	0.00	0	0.00
TOTAL	0	0.00	0	0.00	69,810	0.00	0	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	68,521	0.00	68,521	0.00
TOTAL - PD	0	0.00	0	0.00	68,521	0.00	68,521	0.00
TOTAL	0	0.00	0	0.00	68,521	0.00	68,521	0.00
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	1,642	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	2,703	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	4,345	0.00
TOTAL	0	0.00	0	0.00	0	0.00	4,345	0.00
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	312,451	0.00

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FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	515,987	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	828,438	0.00
TOTAL	0	0.00	0	0.00	0	0.00	828,438	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	61,865	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	101,885	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	163,750	0.00
TOTAL	0	0.00	0	0.00	0	0.00	163,750	0.00
GRAND TOTAL	\$10,207,150	0.00	\$9,362,981	0.00	\$9,236,658	0.00	\$10,163,381	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Dental

Budget Unit: 90546C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	2,515,506	5,662,886	919,935	9,098,327
TRF				
Total	2,515,506	5,662,886	919,935	9,098,327
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)
Healthy Families Trust Fund (0625)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	2,515,506	5,662,886	919,935	9,098,327
TRF				
Total	2,515,506	5,662,886	919,935	9,098,327
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)
Healthy Families Trust Fund (0625)

2. CORE DESCRIPTION

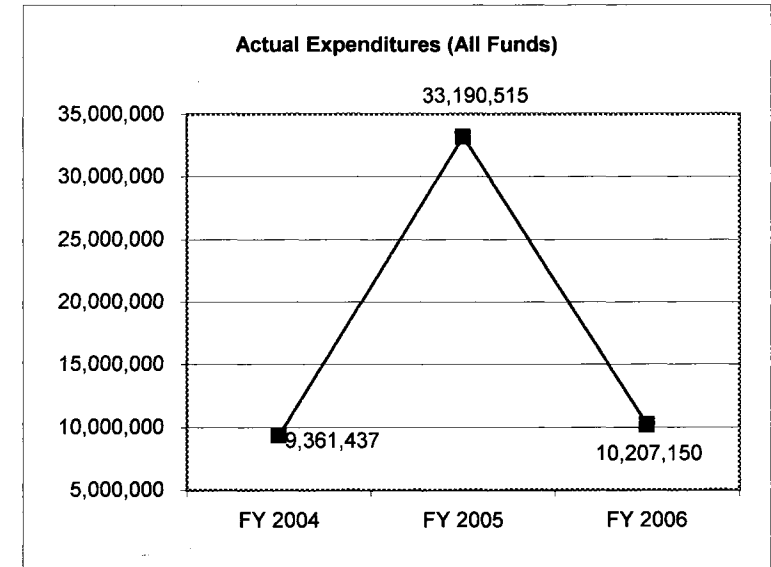
This core request is for the continued funding of the dental fee-for-service program. Funding provides dental services for children, pregnant women, the blind, and nursing facility residents in the defined non-managed care Medicaid population.

3. PROGRAM LISTING (list programs included in this core funding)

Dental Services

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	9,363,572	33,192,650	10,209,285	9,362,981
Less Reverted (All Funds)	(2,135)	(2,135)	(2,135)	N/A
Budget Authority (All Funds)	9,361,437	33,190,515	10,207,150	N/A
Actual Expenditures (All Funds)	9,361,437	33,190,515	10,207,150	N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

- (1) FY04 funding cut for adult dental services - services continued through a court order. Expenditures of \$22,786,492 were paid from the Supplemental Pool.
- (2) Expenditures of \$5,246,342 were paid from the Supplemental pool in FY 2005.
- (3) SB 539 eliminated adult dental services. Expenditures of \$13,229,886 were paid from the Supplemental pool in FY 2006.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
DENTAL

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES								
		PD	0.00	2,658,126	5,784,920	919,935	9,362,981	
		Total	0.00	2,658,126	5,784,920	919,935	9,362,981	
DEPARTMENT CORE ADJUSTMENTS								
Core Reduction	1666 8198	PD	0.00	(74,099)	0	0	(74,099)	Core Cut -- MAWD
Core Reduction	1666 8199	PD	0.00	0	(122,034)	0	(122,034)	Core Cut -- MAWD
Core Reduction	1703 8198	PD	0.00	(68,521)	0	0	(68,521)	FMAP Adjustment
Core Reallocation	2123 5510	PD	0.00	0	0	(848,773)	(848,773)	Reallocation from #0640 to #0625
Core Reallocation	2123 3708	PD	0.00	0	0	848,773	848,773	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES			0.00	(142,620)	(122,034)	0	(264,654)	
DEPARTMENT CORE REQUEST								
		PD	0.00	2,515,506	5,662,886	919,935	9,098,327	
		Total	0.00	2,515,506	5,662,886	919,935	9,098,327	
GOVERNOR'S RECOMMENDED CORE								
		PD	0.00	2,515,506	5,662,886	919,935	9,098,327	
		Total	0.00	2,515,506	5,662,886	919,935	9,098,327	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DENTAL								
CORE								
PROGRAM DISTRIBUTIONS	10,207,150	0.00	9,362,981	0.00	9,098,327	0.00	9,098,327	0.00
TOTAL - PD	10,207,150	0.00	9,362,981	0.00	9,098,327	0.00	9,098,327	0.00
GRAND TOTAL	\$10,207,150	0.00	\$9,362,981	0.00	\$9,098,327	0.00	\$9,098,327	0.00
GENERAL REVENUE	\$2,934,135	0.00	\$2,658,126	0.00	\$2,515,506	0.00	\$2,515,506	0.00
FEDERAL FUNDS	\$6,355,215	0.00	\$5,784,920	0.00	\$5,662,886	0.00	\$5,662,886	0.00
OTHER FUNDS	\$917,800	0.00	\$919,935	0.00	\$919,935	0.00	\$919,935	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Dental

Program is found in the following core budget(s): Dental

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for dental services for fee for service Medicaid/MC+ recipients eligible for dental services.

Dental services are typically those diagnostic, preventative and corrective procedures provided by a licensed dentist or dental hygienist performing within his/her scope of practice. The dentist must be enrolled in the Missouri Medicaid program. Generally, dental services include: treatment of the teeth and associated structure of the oral cavity; preparation, fitting and repair of dentures and associated appliances; and treatment of disease, injury or impairments that affect the general oral health of a recipient.

To participate in the Medicaid/MC+ program, a dentist must be licensed by the Missouri Dental Board and have a signed Title XIX Participation Agreement. The services of a dentist may be administered in a variety of settings including the provider's office, a hospital, nursing home or clinic. The fees paid to the provider are based on Maximum Allowable Amounts identified on a fee schedule. Prior authorization is required for certain services, such as orthodontic treatment, composite resin crowns, metallic and porcelain/ceramic inlay restorations, high noble metal crowns, etc.

Effective September 1, 2005, Missouri Medicaid will only cover dental services for adults (except individuals under a category of assistance for pregnant women or the blind or nursing facility residents) if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a disease/medical condition without which the health of the individual would be adversely affected. These services require a prior authorization. Dental Services for children ages 20 and under remain unchanged.

Covered services under the dental program include, but are not limited to, examinations, prophylaxis, fluoride treatments, extractions, anesthesia, crowns, dentures (full or partial), denture adjustments or repairs, denture duplication or reline, injections, oral surgery, periodontic treatment (in limited cases), pulp treatment, restorations, root canal therapy and x-rays. Orthodontic services, the field of dentistry associated with the correction of abnormally positioned or misaligned teeth, are available only to those eligibles age 20 and under for the most handicapping malocclusions.

A copayment, a portion of the providers' charges paid by the recipient, is required on many dental services. Recipients under age 19, hospice recipients, recipients who reside in nursing facilities, residential care facilities, psychiatric hospitals or adult boarding homes, and recipients age 18-21 in foster care are exempt from copayments. The copayment, in accordance with title 42 Code of Federal Regulations part 447.54, is based on the lesser of the provider's usual charge for the service or the Maximum Allowable Amount. The copayment is \$.50 for charges of \$10.00 or less, \$1.00 for \$10.01 to \$25.00, \$2.00 for \$25.01 to \$50.00 and \$3.00 for charges of \$50.01 or more. Reimbursement for services to individuals not subject to the copayment is determined by adding together the maximum allowable amount plus one-half the recipient cost share amount listed for the procedure. This formula represents the minimum amount allowed for the procedure code. Reimbursement is made at the lower of the providers billed amount or the Maximum Allowed less any TPL.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State: RSMo. 208.152, 208.166; Federal law: Social Security Act Section 1905(a)(10); Federal regulation: 42 CFR 440.100

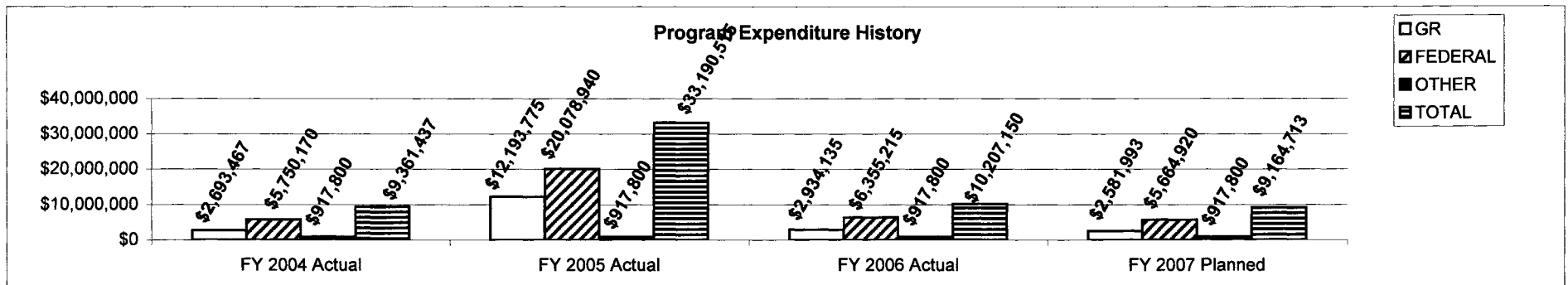
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

No for adults. Yes for children.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



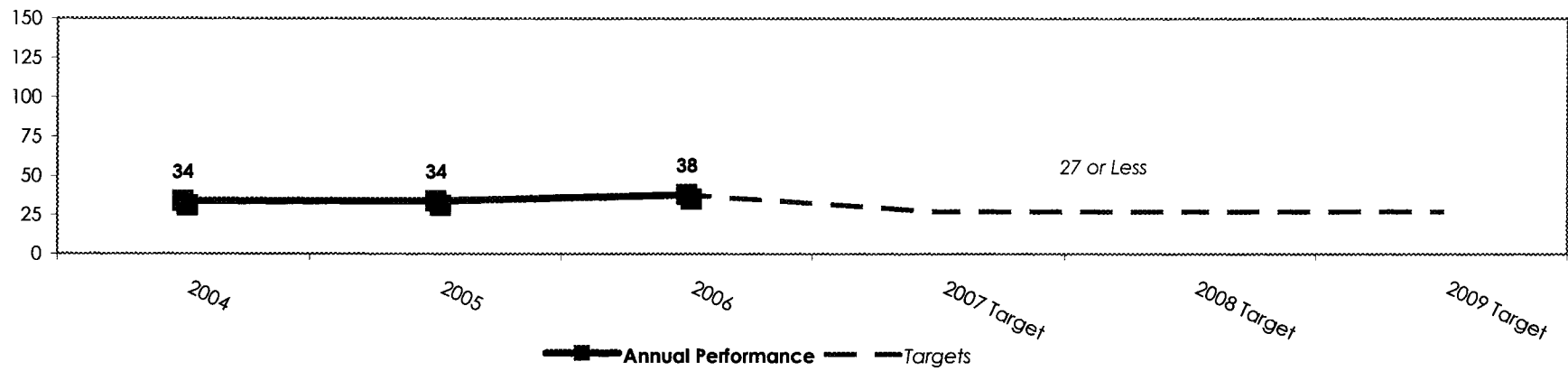
Note: FY04 appropriation was cut to eliminate adult dental services. Services were restored and payments for adult dental were paid from the Medicaid supplemental pool.

6. What are the sources of the "Other" funds?

Health Initiatives Fund (0275) and Healthy Families Trust Fund-Health Care Account (0640)

7a. Provide an effectiveness measure.

Maintain Medicaid Provider Enrollment Application Backlog
(in Days)



7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Dental services are available to all Medicaid eligibles*. In the regions of the state where MC+ managed care has been implemented, child enrollees have dental services available through the MC+ managed care health plans.

*Effective September 1, 2005 dental services are available only to children, pregnant women, the blind, and nursing facility residents. Dental services are available to other adults if the dental care is related to trauma or a disease/medical condition. Qualified Medicare Beneficiaries (QMB's) and 1115 Waiver Adults are not eligible for dental services.

Users of Dental Services Average/Month		
SFY	Actual	Projected
2004	13,496	11,284
2005	16,039	15,624
2006	9,286	7,293
2007		11,605
2008		13,924
2009		16,243

Average Cost/Service		
SFY	Actual	Projected
2004	\$43.43	\$44.20
2005	\$43.45	\$44.14
2006	\$41.32	\$39.87
2007		\$41.34
2008		\$41.36
2009		\$41.38

Average Units/Service Average/Month		
SFY	Actual	Projected
2004	3.88	4.19
2005	4.07	4.50
2006	4.18	4.15
2007		4.29
2008		4.41
2009		4.53

7d. Provide a customer satisfaction measure, if available.

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
PREMIUM PAYMENTS									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	47,321,576	0.00	55,403,185	0.00	54,461,244	0.00	54,461,244	0.00	
TITLE XIX-FEDERAL AND OTHER	73,353,870	0.00	90,726,492	0.00	90,726,492	0.00	90,726,492	0.00	
TOTAL - PD	120,675,446	0.00	146,129,677	0.00	145,187,736	0.00	145,187,736	0.00	
TOTAL	120,675,446	0.00	146,129,677	0.00	145,187,736	0.00	145,187,736	0.00	
Medicaid Caseload Growth - 1886033									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	81,920	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	134,914	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	216,834	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	216,834	0.00	0	0.00	
Premium Increase - 1886037									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	2,805,391	0.00	2,805,391	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	4,621,170	0.00	4,621,170	0.00	
TOTAL - PD	0	0.00	0	0.00	7,426,561	0.00	7,426,561	0.00	
TOTAL	0	0.00	0	0.00	7,426,561	0.00	7,426,561	0.00	
FMAP - 1886035									
PROGRAM-SPECIFIC									
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	941,941	0.00	941,941	0.00	
TOTAL - PD	0	0.00	0	0.00	941,941	0.00	941,941	0.00	
TOTAL	0	0.00	0	0.00	941,941	0.00	941,941	0.00	
GRAND TOTAL	\$120,675,446	0.00	\$146,129,677	0.00	\$153,773,072	0.00	\$153,556,238	0.00	

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Premium Payments

Budget Unit: 90547C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	54,461,244	90,726,492		145,187,736
TRF				
Total	<u>54,461,244</u>	<u>90,726,492</u>		<u>145,187,736</u>
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	54,461,244	90,726,492		145,187,736
TRF				
Total	<u>54,461,244</u>	<u>90,726,492</u>		<u>145,187,736</u>
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

2. CORE DESCRIPTION

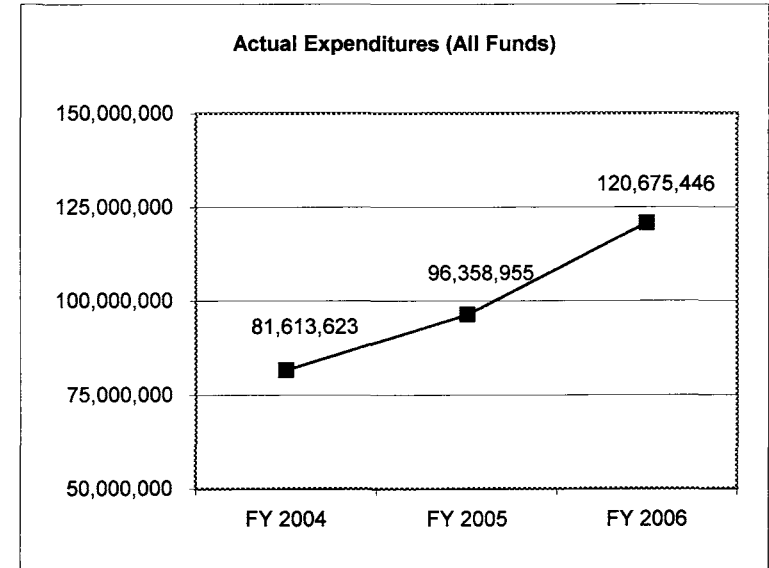
This core request is for the ongoing funding for premium payments for health insurance through the following Medicaid programs: Medicare Buy-In and the Health Insurance Premium Payment (HIPP) program.

3. PROGRAM LISTING (list programs included in this core funding)

Premium Payments Program:
Medicare Part A and Part B Buy-In
Health Insurance Premium Payment (HIPP) Program

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	81,613,623	96,359,288	125,838,041	146,129,677
Less Reverted (All Funds)	0	0	(102,896)	N/A
Budget Authority (All Funds)	81,613,623	96,359,288	125,735,145	N/A
Actual Expenditures (All Funds)	81,613,623	96,358,955	120,675,446	N/A
Unexpended (All Funds)	0	333	5,059,699	N/A
Unexpended, by Fund:				
General Revenue	0	129	140,478	N/A
Federal	0	204	4,919,221	N/A
Other	0	0	0	N/A
	(1)	(2)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Expenditures of \$3,708,058 were paid from the Supplemental Pool.

(2) Expenditures of \$6,926,710 were paid from the Supplemental Pool.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

PREMIUM PAYMENTS

5. CORE RECONCILIATION DETAIL

				Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES										
				PD	0.00	55,403,185	90,726,492	0	146,129,677	
				Total	0.00	55,403,185	90,726,492	0	146,129,677	
DEPARTMENT CORE ADJUSTMENTS										
Core Reduction	1704	8200		PD	0.00	(941,941)	0	0	(941,941)	FMAP Adjustment
NET DEPARTMENT CHANGES					0.00	(941,941)	0	0	(941,941)	
DEPARTMENT CORE REQUEST										
				PD	0.00	54,461,244	90,726,492	0	145,187,736	
				Total	0.00	54,461,244	90,726,492	0	145,187,736	
GOVERNOR'S RECOMMENDED CORE										
				PD	0.00	54,461,244	90,726,492	0	145,187,736	
				Total	0.00	54,461,244	90,726,492	0	145,187,736	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PREMIUM PAYMENTS								
CORE								
PROGRAM DISTRIBUTIONS	120,675,446	0.00	146,129,677	0.00	145,187,736	0.00	145,187,736	0.00
TOTAL - PD	120,675,446	0.00	146,129,677	0.00	145,187,736	0.00	145,187,736	0.00
GRAND TOTAL	\$120,675,446	0.00	\$146,129,677	0.00	\$145,187,736	0.00	\$145,187,736	0.00
GENERAL REVENUE	\$47,321,576	0.00	\$55,403,185	0.00	\$54,461,244	0.00	\$54,461,244	0.00
FEDERAL FUNDS	\$73,353,870	0.00	\$90,726,492	0.00	\$90,726,492	0.00	\$90,726,492	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Premium Payments

Program is found in the following core budget(s): Premium Payments

1. What does this program do?

PROGRAM SYNOPSIS: This program pays for health insurance premiums for eligible recipients. Payments include premiums for Medicare Part A, Medicare Part B and group health insurance premiums provided under the Health Insurance Premium Payment (HIPP) program. Payment of these premiums transfers medical costs from Medicaid to Medicare and other payers.

Buy-In:

The Buy-in Program allows states to enroll certain groups of eligible individuals in the Medicare program and pay their premiums. The purpose of buy-in is to permit the state, as part of its total assistance plan, to provide Medicare protection to certain groups of eligible individuals. It transfers medical costs from the Title XIX Medicaid program to the Medicare program - Title XVIII. This process allows the state to realize cost savings through substitution of Medicare liability for the majority of the medical costs before Medicaid reimburses for the services. There are two types of buy-in agreements - "1634 agreements" and "209b". States with "1634 agreements" have the same Medicaid eligibility standards as the Supplemental Security Income (SSI) program. States with more restrictive eligibility standards for Medicaid are "209b" states. The "209b" states make their own buy-in determinations. Missouri is a 209b state.

The Medicare program is divided into two parts - Part A and Part B. Part A covers hospital, skilled nursing facility, home health, and hospice care. There are deductibles and coinsurance, but most people do not pay premiums for Part A. There is no premium for workers (and their spouse) who have at least ten years of Social Security covered employment. Services covered under Part B are doctors' services, outpatient hospital services, durable medical equipment, home health care, and other medical services. Part B has premiums, deductibles, and coinsurance amounts that the individual is responsible for paying. Premium, deductible and coinsurance amounts are set each year based on formulas established by law. New payment amounts are set each January 1.

The buy-in for Part A began in FY 90 (September 1989). The Part B buy-in has been a Medicaid service since January 1968.

Health Insurance Premium Payment:

The Health Insurance Premium Payment (HIPP) program is a program that pays for the cost of health insurance premiums, coinsurance, and deductibles. The program pays for health insurance for Medicaid eligibles when it is "cost effective". "Cost effective" means that it costs less to buy health insurance to cover medical care than to pay for the same services with Medicaid funds. Cost effectiveness is determined by comparing the cost of the medical coverage (includes premium payments, coinsurance, and deductibles) with the average cost of each Medicaid-eligible person in the household. The average cost of each Medicaid recipient is based on the previous year's Medicaid expenditures with like demographic data - age, sex, geographic location (county), type of assistance (MAF, OAA, and disabled), and the types of services covered by the group insurance. The HIPP program has been a Medicaid program since September 1992.

The HIPP program is beneficial in a managed care environment. The emphasis shifts more to the "high risk" or "high utilizer" populations. Recipients in this group will at some point reach a "stop loss" situation with the managed care plan and revert to total Medicaid dollars (not just a capitated fee). By "buying in" the recipients when insurance is available, the private insurance will pay for their care instead of the Medicaid program.

Provisions of OBRA 90 require states to purchase group health insurance (such as a job based plan) for a Medicaid recipient (who is eligible to enroll for the coverage) when it is more cost-effective to buy health insurance to cover medical care than to pay for an equivalent set of services with Medicaid funds.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.153; Federal law: Social Security Act Section 1905(p)(1), 1902(a)(10) and 1906; Federal Regulation: 42 CFR 406.26 and 431.625

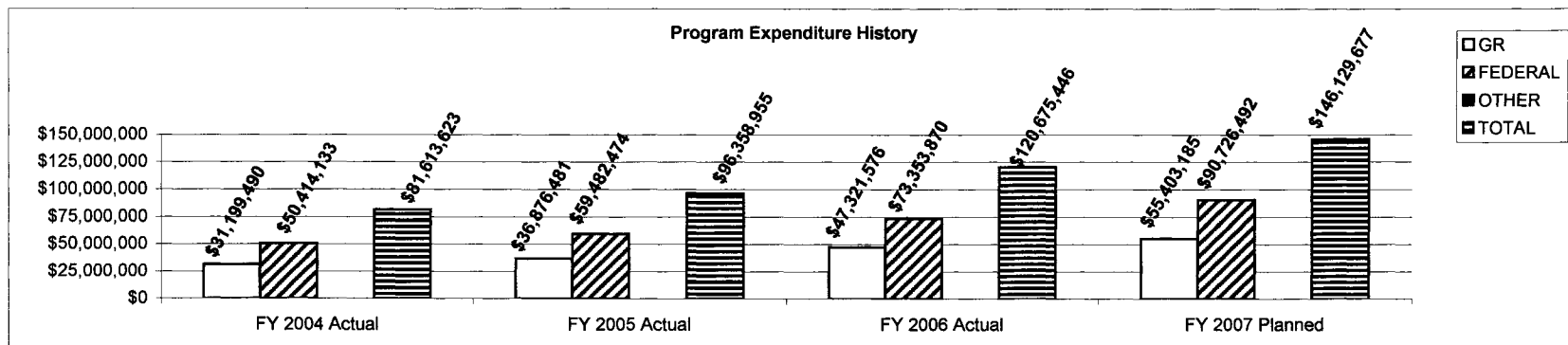
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Yes, if the state elects to have a Medicaid program.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

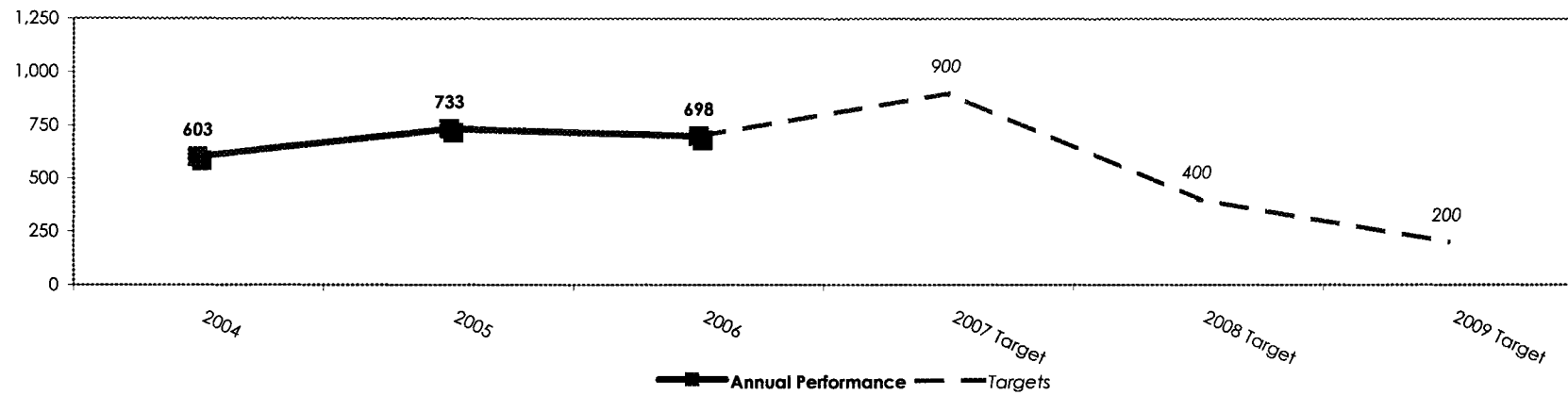


6. What are the sources of the "Other" funds?

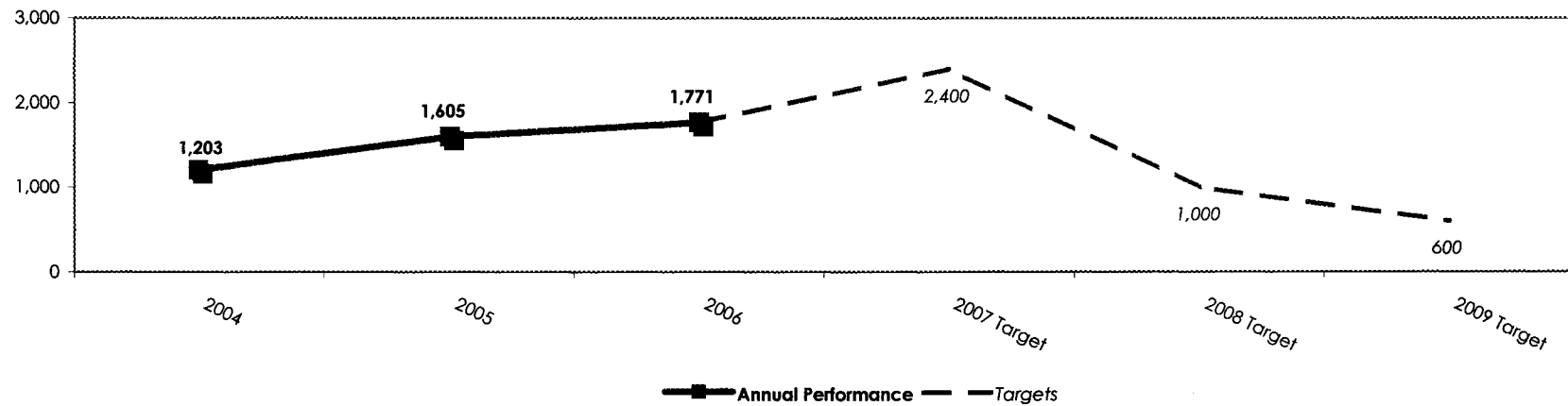
N/A

7a. Provide an effectiveness measure.

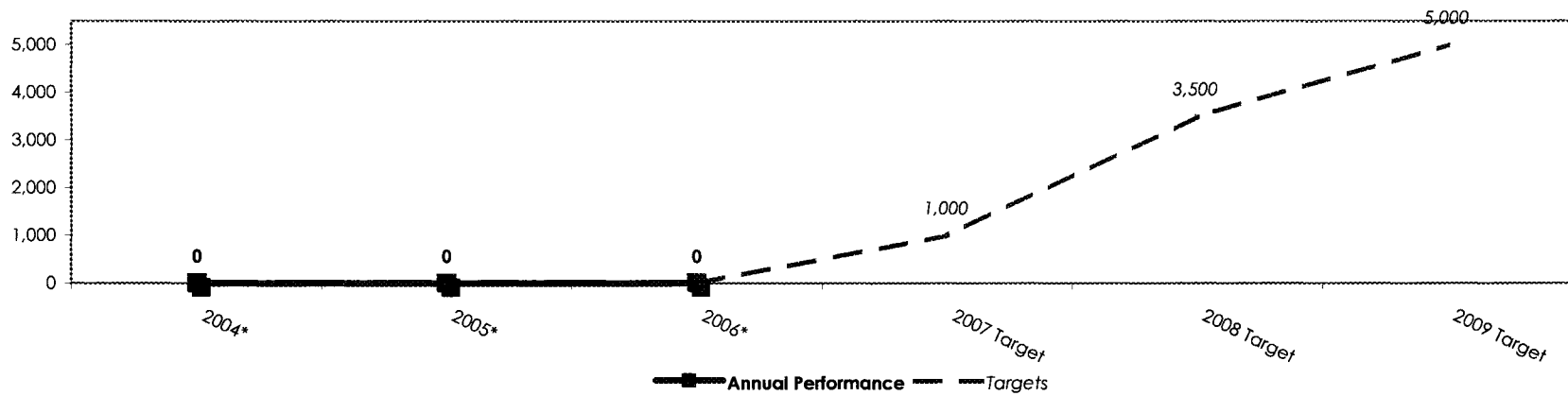
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

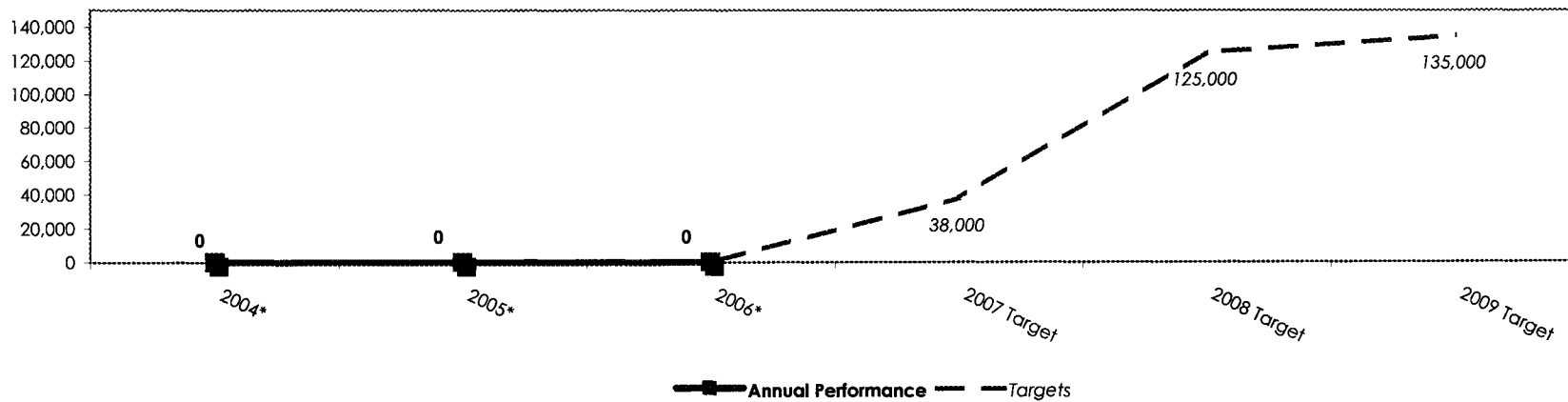


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

HIPP Cost Avoidance		
SFY	Actual	Projected
2004	\$1.93 Mil	N/A
2005	\$2.55 Mil	N/A
2006	\$2.29 Mil	\$2.50 Mil
2007		\$2.50 Mil
2008		\$2.50 Mil
2009		\$2.50 Mil

7c. Provide the number of clients/individuals served, if applicable.

Recipients Receiving Premium Payment						
	Part A		Part B		HIPP	
SFY	Actual	Projected	Actual	Projected	Actual	Projected
2004	735	690	101,096	98,322	*	*
2005	792	766	106,394	105,480	7,953	*
2006	859	855	110,181	111,714	8,640	8,351
2007		921		114,724		9,387
2008		987		119,454		10,197
2009		1,058		124,376		11,079

*Not Available

Eligibles:

• Part A (Hospital) premium payment can be made for:

- Qualified Medicare Beneficiaries (QMBs)
- Qualified Disabled Working Individuals

• Part B (Medical) premium payment can be made for:

- Individuals that meet certain income standards
- Qualified Medicare Beneficiaries (QMBs)
- Specified Low-Income Medicare Beneficiaries

• HIPP:

- Provisions of OBRA 90 require states to purchase group health insurance for a Medicaid recipient when it is more cost effective to buy health insurance to cover medical care than to pay for an equivalent set of services with Medicaid funds.

7d. Provide a customer satisfaction measure, if available.

NEW DECISION ITEM

RANK: 21

Department: Social Services
Division: Medical Services
DI Name: Medicare Premium Increases

Budget Unit: 90547C

DI#: 1886037

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	2,805,391	4,621,170		7,426,561
TRF				
Total	2,805,391	4,621,170		7,426,561
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	2,805,391	4,621,170		7,426,561
TRF				
Total	2,805,391	4,621,170		7,426,561
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding is requested for anticipated Medicare Part A and Part B increases.

Federal law mandates that the Medicare Part A and Part B premiums cover a certain percentage of the cost of the Medicare program. Medicare Part A and Part B premiums are adjusted each January. In FY08, Part A premiums are estimated to be \$428 which consists of FY07 - \$410 plus a \$18.00 increase. In FY08, Part B premiums are estimated to be \$98.78 which consists of FY07 - \$93.50 plus a \$5.28 increase. The Federal Authority is Social Security Act Section 1905(p)(1), 1902(a)(10), and 1906 and Federal Regulations 42 CFR 406.26 and 431.625. State Authority is 208.153.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

The request is for six months of funding for the calendar year 2007 premium increases and six months of funding for the expected calendar year 2008 premium increases.

Projected eligibles are based on historical data. The projected premium increases are based on the average increases in premiums over the last few years as well as other information sources.

The federal matching rate used for increases for the period July 2007 through September 2007 is 61.60%. The federal matching rate used for increases for the period October 2007 through June 2008 is 62.42%.

	Part A	Part B	Total
Eligibles per month (FY07)	921	114,724	
Eligibles per month (FY08)	987	119,454	
Premium Increase 1/07	\$17	\$5.00	
Premium Increase 1/08	\$18	\$5.28	
<u>Calendar Year 2007 Increase:</u>			
Average eligibles per month	921	114,724	
Premium increase for 2007	\$17	\$5.00	
Number of months of increase	6	6	
Projected increase 7/07 -12/07	\$93,942	\$3,441,720	\$3,535,662
<u>Calendar Year 2008 Increase:</u>			
Average eligibles per month	987	119,454	
Premium increase for 2008	\$18	\$5.28	
Number of months of increase	6	6	
Projected increase 1/08 - 6/08	\$106,596	\$3,784,303	\$3,890,899
Total	\$200,538	\$7,226,023	\$7,426,561
GR	\$75,744	\$2,729,647	\$2,805,391
Federal	\$124,794	\$4,496,376	\$4,621,170

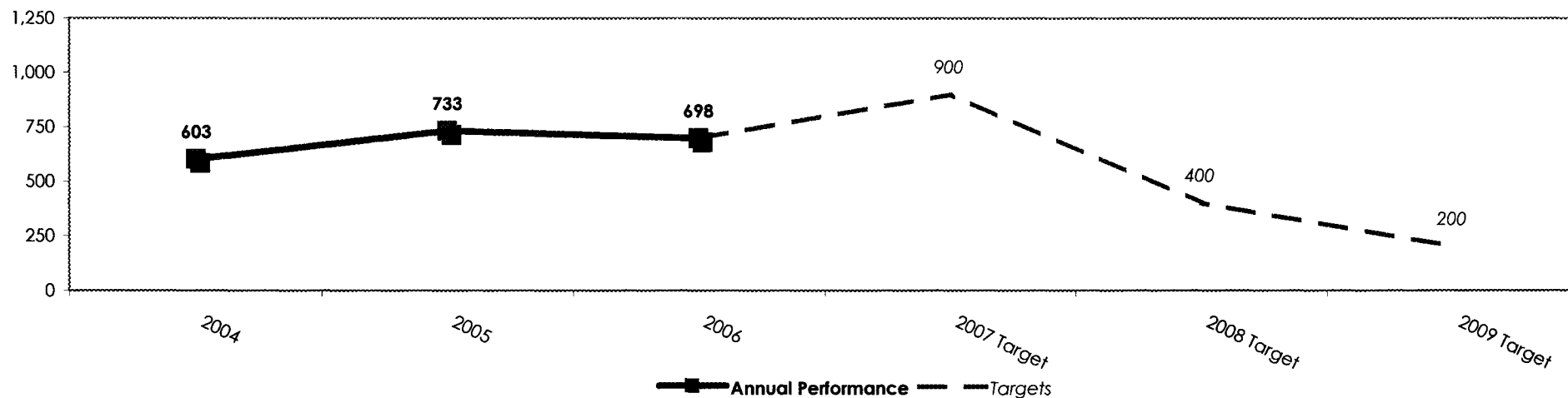
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	2,805,391		4,621,170				7,426,561		
Total PSD	2,805,391		4,621,170		0		7,426,561		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	2,805,391	0.0	4,621,170	0.0	0	0.0	7,426,561	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	2,805,391		4,621,170				7,426,561		
Total PSD	2,805,391		4,621,170		0		7,426,561		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	2,805,391	0.0	4,621,170	0.0	0	0.0	7,426,561	0.0	0

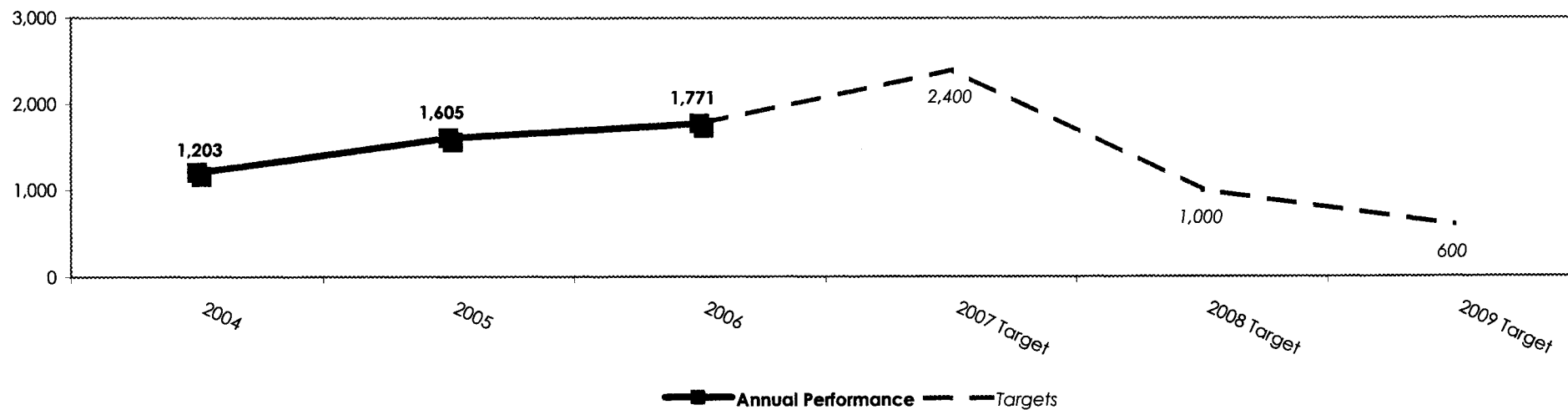
6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

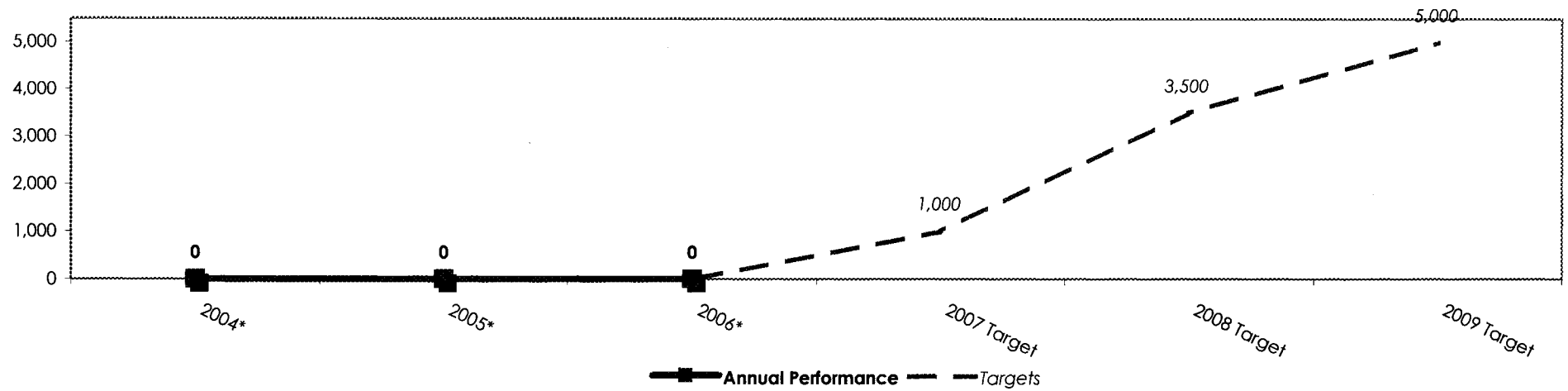
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

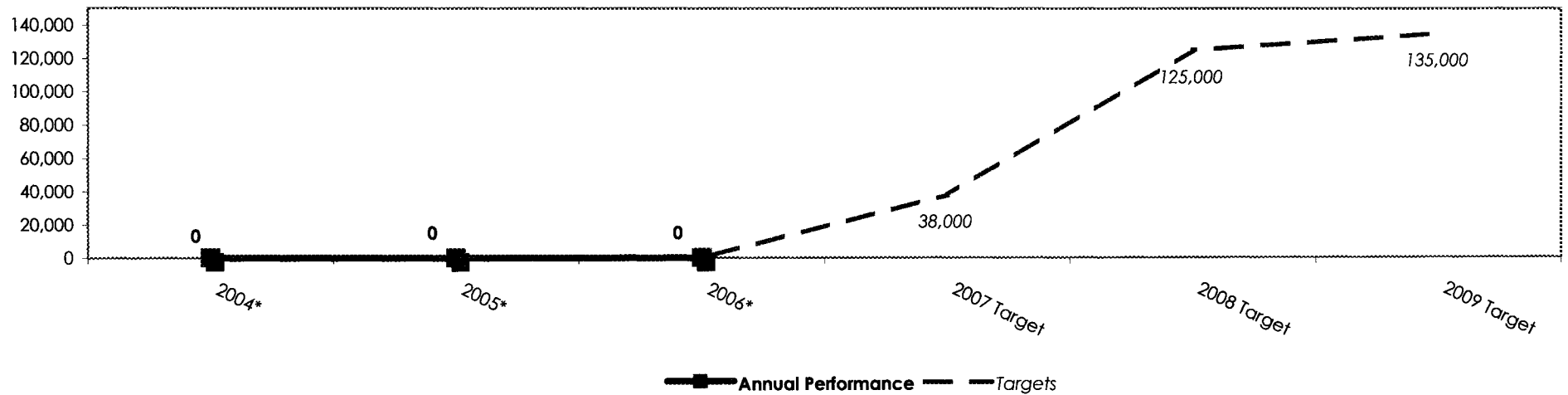


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Recipients Receiving Premium Payment				
	Part A		Part B	
SFY	Actual	Projected	Actual	Projected
2004	735	690	101,096	98,322
2005	792	766	106,394	105,480
2006	859	855	110,181	111,714
2007		921		114,724
2008		987		119,454
2009		1,058		124,376

Eligibles:

- Part A (Hospital) premium payment can be made for:
 - Qualified Medicare Beneficiaries (QMBs)
 - Qualified Disabled Working Individuals
- Part B (Medical) premium payment can be made for:
 - Individuals that meet certain income standards
 - Qualified Medicare Beneficiaries (QMBs)
 - Specified Low-Income Medicare Beneficiaries

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Work with awarded vendor to establish the Chronic Care Improvement Program (CCIP) for health care management to improve health care quality for patients with chronic illness and disease.
- Maintain the disease management (DM) program and focus on intensive outreach / growing the CCIP.
- Establish dedicated CCIP help desks for provider and recipient support. Continue DM help desks.
- Utilize internet-based plan of care as part of the chronic care improvement program.
- Continue outreach efforts through recipient mailings and direct promotion by their current practitioner.
- Continue statewide identification of recipients with targeted disease states.
- Inform providers of the clinical and financial benefits of participating in Disease Management and the Chronic Care Programs.
- Reinforce clinical areas for improvement and provide clinical education where appropriate.
- Expand the number of CyberAccess users and utilize SmartMed™ Prior Authorization for durable medical equipment, and other selected medical procedures.

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
PREMIUM PAYMENTS								
Premium Increase - 1886037								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	7,426,561	0.00	7,426,561	0.00
TOTAL - PD	0	0.00	0	0.00	7,426,561	0.00	7,426,561	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$7,426,561	0.00	\$7,426,561	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,805,391	0.00	\$2,805,391	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$4,621,170	0.00	\$4,621,170	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
Nursing Fac Per Diem Rate Incr - 1886054								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	10,000,000	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	16,470,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	26,470,000	0.00
TOTAL	0	0.00	0	0.00	0	0.00	26,470,000	0.00
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	102,585,653	0.00	127,882,900	0.00	123,649,950	0.00	123,649,950	0.00
TITLE XIX-FEDERAL AND OTHER	270,226,830	0.00	306,109,043	0.00	303,402,792	0.00	303,402,792	0.00
UNCOMPENSATED CARE FUND	58,516,478	0.00	58,516,478	0.00	58,516,478	0.00	58,516,478	0.00
THIRD PARTY LIABILITY COLLECT	2,293,103	0.00	2,592,981	0.00	2,592,981	0.00	2,592,981	0.00
NURSING FACILITY FED REIM ALLW	1,072,122	0.00	1,072,064	0.00	0	0.00	0	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	17,973	0.00	17,973	0.00
HFT-HEALTH CARE ACCT	17,973	0.00	17,973	0.00	0	0.00	0	0.00
TOTAL - PD	434,712,159	0.00	496,191,439	0.00	488,180,174	0.00	488,180,174	0.00
TOTAL	434,712,159	0.00	496,191,439	0.00	488,180,174	0.00	488,180,174	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	2,589,714	0.00	2,589,714	0.00
TOTAL - PD	0	0.00	0	0.00	2,589,714	0.00	2,589,714	0.00
TOTAL	0	0.00	0	0.00	2,589,714	0.00	2,589,714	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	5,155	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	8,491	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	13,646	0.00
TOTAL	0	0.00	0	0.00	0	0.00	13,646	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
Provider Tax GR Replacement - 1886066								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	4,231,833	0.00	4,231,833	0.00
TOTAL - PD	0	0.00	0	0.00	4,231,833	0.00	4,231,833	0.00
TOTAL	0	0.00	0	0.00	4,231,833	0.00	4,231,833	0.00
GRAND TOTAL	\$434,712,159	0.00	\$496,191,439	0.00	\$495,001,721	0.00	\$521,485,367	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Nursing Facilities

Budget Unit: 90549C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	123,649,950	303,402,792	61,127,432	488,180,174
TRF				
Total	<u>123,649,950</u>	<u>303,402,792</u>	<u>61,127,432</u>	<u>488,180,174</u>
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Uncompensated Care Fund (UCF) (0108)
Nursing Facility Federal Reimbursement Allowance Fund (NFRA) (0196)
Healthy Families Trust Fund (0625)
Third Party Liability Collections Fund (TPL) (0120)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	123,649,950	303,402,792	61,127,432	488,180,174
TRF				
Total	<u>123,649,950</u>	<u>303,402,792</u>	<u>61,127,432</u>	<u>488,180,174</u>
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Uncompensated Care Fund (UCF) (0108)
Nursing Facility Federal Reimb Allowance Fund (NFRA) (0196)
Healthy Families Trust Fund (0625)
Third Party Liability Collections Fund (TPL) (0120)

2. CORE DESCRIPTION

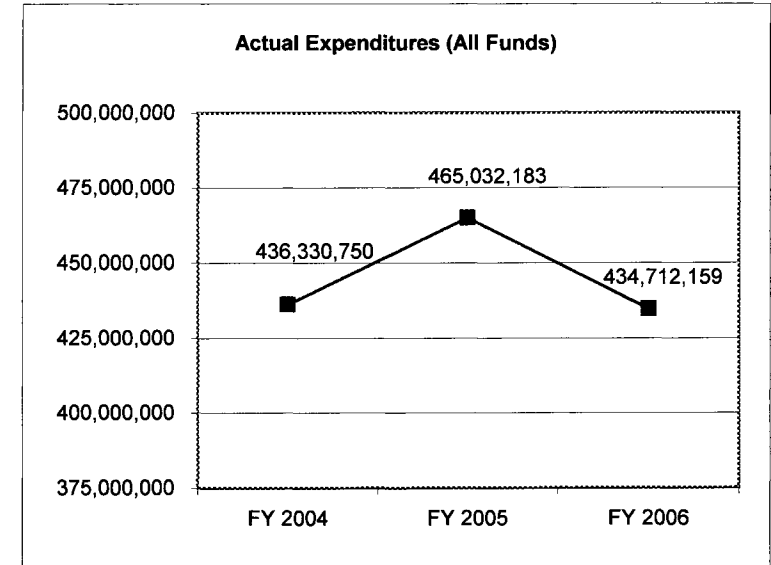
This core is for ongoing funding for payments for long-term nursing care for Medicaid (Title XIX) recipients.

3. PROGRAM LISTING (list programs included in this core funding)

Nursing Facilities

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	446,053,834	469,007,183	434,712,159	496,191,439
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	446,053,834	469,007,183	434,712,159	N/A
Actual Expenditures (All Funds)	436,330,750	465,032,183	434,712,159	N/A
Unexpended (All Funds)	9,723,084	3,975,000	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	895,931	0	0	N/A
Other	8,827,153	3,975,000	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Agency reserve of \$7,000,000 - NFRA Tax. There was no cash to support the NFRA authority. This authority was core cut from the FY 2005 budget. Lapse of \$1,827,153 is IGT. There was no cash to support the IGT authority. The IGT authority was cut from the FY 2006 budget. Expenditures totaling \$380,000 were paid from the Supplemental Pool.

(2) Agency reserve of \$3,975,000 - TPL and IGT. There was no cash to support the NFRA authority. Expenditures of \$10,488,972 were paid from the Supplemental Pool.

(3) Expenditures of \$30,673,390 were paid from the Supplemental pool in FY 2006.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
NURSING FACILITIES

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			PD	0.00	127,882,900	306,109,043	62,199,496	496,191,439	
			Total	0.00	127,882,900	306,109,043	62,199,496	496,191,439	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1674 6473	PD		0.00	0	(2,706,251)	0	(2,706,251)	Increase in Patient Surplus
Core Reduction	1674 6472	PD		0.00	(1,643,236)	0	0	(1,643,236)	Increase in Patient Surplus
Core Reduction	1707 6472	PD		0.00	(2,589,714)	0	0	(2,589,714)	FMAP Adjustment
Core Reduction	3362 5654	PD		0.00	0	0	(1,072,064)	(1,072,064)	Core Reduction - Provider Tax Cap Reduction
Core Reallocation	2122 5511	PD		0.00	0	0	(17,973)	(17,973)	Reallocation from #0640 to #0625
Core Reallocation	2122 3709	PD		0.00	0	0	17,973	17,973	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES				0.00	(4,232,950)	(2,706,251)	(1,072,064)	(8,011,265)	
DEPARTMENT CORE REQUEST									
		PD		0.00	123,649,950	303,402,792	61,127,432	488,180,174	
		Total		0.00	123,649,950	303,402,792	61,127,432	488,180,174	
GOVERNOR'S RECOMMENDED CORE									
		PD		0.00	123,649,950	303,402,792	61,127,432	488,180,174	
		Total		0.00	123,649,950	303,402,792	61,127,432	488,180,174	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
CORE								
PROGRAM DISTRIBUTIONS	434,712,159	0.00	496,191,439	0.00	488,180,174	0.00	488,180,174	0.00
TOTAL - PD	434,712,159	0.00	496,191,439	0.00	488,180,174	0.00	488,180,174	0.00
GRAND TOTAL	\$434,712,159	0.00	\$496,191,439	0.00	\$488,180,174	0.00	\$488,180,174	0.00
GENERAL REVENUE	\$102,585,653	0.00	\$127,882,900	0.00	\$123,649,950	0.00	\$123,649,950	0.00
FEDERAL FUNDS	\$270,226,830	0.00	\$306,109,043	0.00	\$303,402,792	0.00	\$303,402,792	0.00
OTHER FUNDS	\$61,899,676	0.00	\$62,199,496	0.00	\$61,127,432	0.00	\$61,127,432	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Nursing Facilities

Program is found in the following core budget(s): Nursing Facilities

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for long term nursing care for Medicaid recipients.

This program provides long-term institutional care for Title XIX Medicaid recipients. In SFY 06, an average of 500 nursing homes were enrolled in the Medicaid program with an average of 24,842 recipients per month. Nursing facility care users are 2.78% of the total Medicaid eligibles. However, the nursing facility program comprises almost 14.83% of the total program dollars.

Payment is based on a per diem. A per diem rate is established for each nursing home by the Institutional Reimbursement Unit (IRU) of the Division of Medical Services. During the SFY 06 legislative session, a quality improvement adjustment was granted which increased all nursing facility rates by \$3.17 per day effective dates of services beginning July 1, 2006.

The current reimbursement methodology is based on a cost component system. The components are patient care, ancillary, administration, and capital. A working capital allowance, incentives and the Nursing Facility Reimbursement Allowance (NFRA) are also elements of the total reimbursement rate. Patient care includes nursing, medical supplies, activities, social services, and dietary costs. Ancillary services are therapies, barber and beauty shop, laundry, and housekeeping. Administration includes plant operation costs and administrative costs. Capital costs are reimbursed through a fair rental value methodology. The capital component includes five types of costs: rental value, return, computed interest, borrowing costs and pass through expenses. Property insurance and real estate & personal taxes (the pass through expenses) are the only part of the capital component that is trended. The working capital allowance per diem rate is equal to 1.1 months of the total of the facility's per diem rates for the patient care, ancillary and administration cost components times the prime rate plus 2 percent. There are three incentives which are paid to qualified facilities to encourage patient care expenditures and cost efficiencies in administration. The patient care incentive is 10% of a facility's patient care per diem up to a maximum of 130% of the patient care median. The ancillary incentive is paid to all facilities whose costs are below the ancillary ceiling. The amount is one-half the difference between certain parameters. The multiple component incentive is allowed for facilities whose patient care and ancillary per diem are between 60 - 80% of total per diem and an additional amount is allowed for facilities with high Medicaid utilization. The current NFRA is also included in the total reimbursement rate since it is an allowable Medicaid cost.

The reimbursement system is a prospective system. Once the rate is established on a given cost report year, it will not change until the rates are rebased on another cost report year. This rate may be adjusted for global per diem rate adjustment, such as trends, which are granted to the industry as a whole and are applied to the previously established rate.

Providers are reimbursed based on the Medicaid eligible residents' days of care multiplied by the facility's Title XIX per diem less any patient surplus amount. The amount of money the Title XIX recipient contributes to his or her nursing home care is called patient surplus. The patient surplus is based upon the recipient's income and expenses. The amount of the patient surplus is calculated by a Family Support Division caseworker. The gross income (usually a Social Security benefit check) of the recipient is adjusted for the following: personal standard (this is the amount the recipient may keep for personal use; it is currently \$30); an allotment (this is the money allocated for use by the community spouse or dependent children); and medical deductions (Medicare premiums or private medical insurance premiums that the recipient pays for his own medical coverage). The remainder is the patient surplus. The recipient and the nursing facility are notified of the amount of the patient surplus by the Family Support Division. The nursing home provider is responsible for obtaining the patient surplus from the recipient.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Section 1905(a)(4); Federal Regulations: 42 CFR 440.40 and 440.210

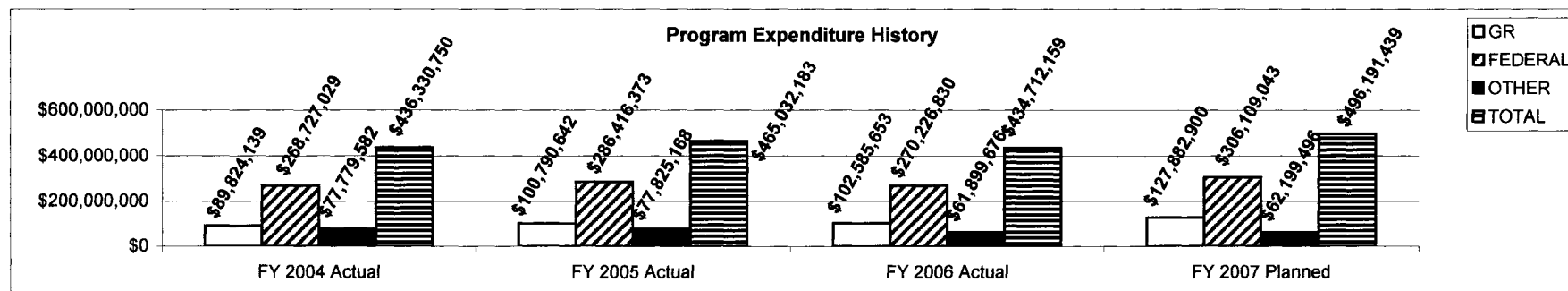
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Yes, for people over age 21.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



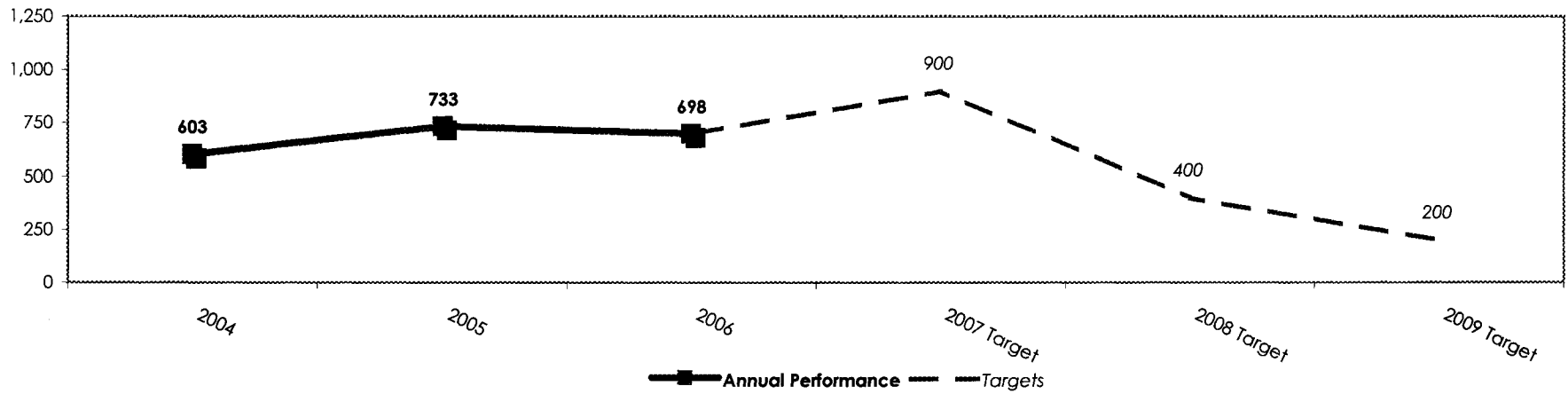
6. What are the sources of the "Other" funds?

Uncompensated Care Fund (0108), Nursing Facility Federal Reimbursement Allowance (0196), Healthy Families Trust Fund-Health Care Account (0640), Third Party Liability Collections Fund (0120) and Intergovernmental Transfer Fund (0139) not available in FY06 and FY07.

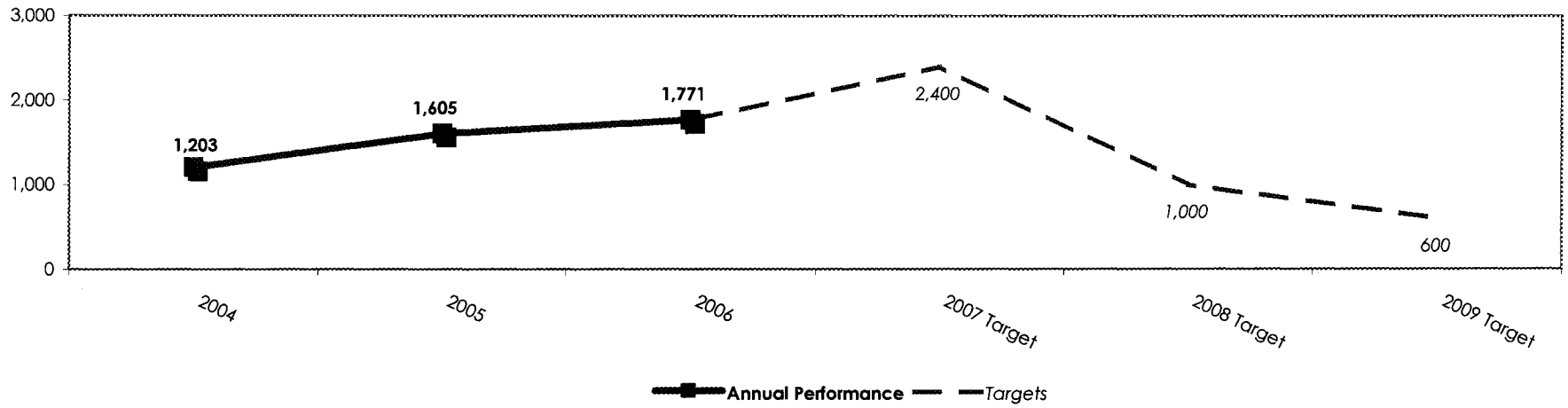
7a. Provide an effectiveness measure.

Nursing Facility Occupancy		
SFY	Actual	Projected
2004	72.5%	
2005	72.3%	
2006	72.6%	72.8%
2007		72.6%
2008		72.6%
2009		72.6%

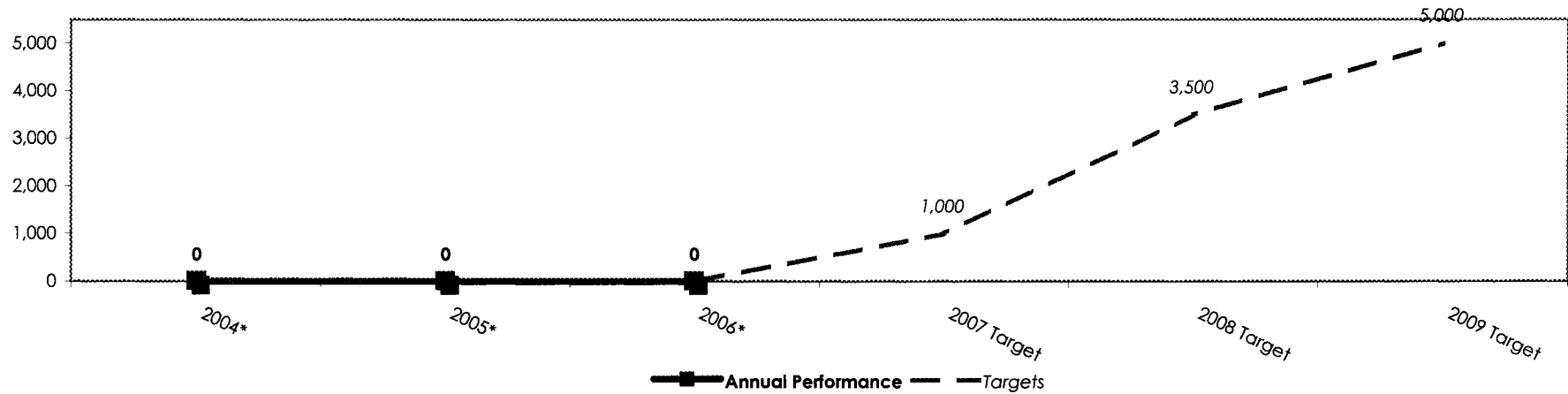
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

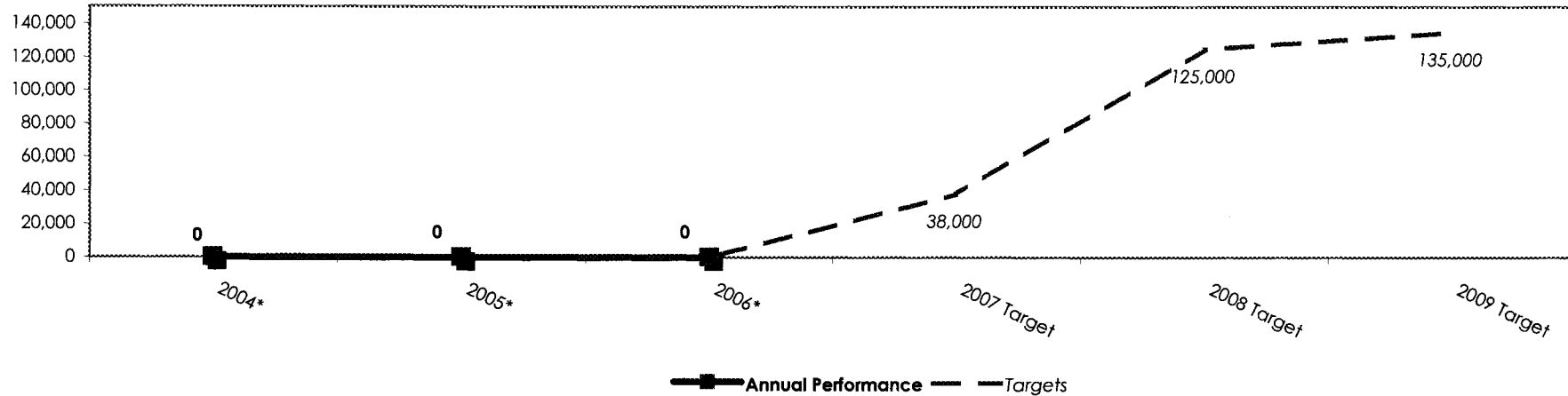


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Average Monthly Medicaid Nursing Facility Users		
SFY	Actual	Projected
2004	24,694	25,469
2005	25,677	24,500
2006	24,842	26,447
2007		25,000
2008		25,000
2009		25,000

Paid Patient Days		
SFY	Actual	Projected
2004	8.9 mil	9.2 mil
2005	8.9 mil	9.1 mil
2006	8.8 mil	9.0 mil
2007		8.8 mil
2008		8.8 mil
2009		8.9 mil

Average Per Diem Rate	
SFY	Actual
2004	\$103.12
2005	\$108.95
2006	\$107.95
2007	\$111.12
2008	
2009	

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 0**

Department: Social Services
Division: Medical Services
DI Name: Nursing Facility Per Diem Rate Increase

Budget Unit: 90549C
DI#: 1886054

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	10,000,000	16,470,000		26,470,000
TRF				
Total	10,000,000	16,470,000		26,470,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funds a \$3.00 per day nursing facility per diem rate increase.

Nursing facilities continue to incur higher costs from providing care to nursing home residents. Adequate reimbursement to providers is essential in order to ensure that providers are willing to participate in the Medicaid program, to help ensure quality care for Missouri's nursing home population and to ensure that reimbursement rates are in accordance with federal legislation.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

A \$3.00 per day increase is recommended. The increase was multiplied by the projected FY 08 NF patient days to arrive at the cost.
 FY 08 projected patient days - 8,823,333 x \$3.00 = \$26,470,000

	GR	Federal	Total
Nursing Facilities	\$10,000,000	\$16,470,000	\$26,470,000

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	10,000,000		16,470,000				26,470,000		
Total PSD	10,000,000		16,470,000		0		26,470,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	10,000,000	0.0	16,470,000	0.0	0	0.0	26,470,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

Nursing Facility Occupancy		
SFY	Actual	Projected
2004	72.5%	
2005	72.3%	
2006	72.6%	72.8%
2007		72.6%
2008		72.6%
2009		72.6%

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Average Monthly Medicaid Nursing Facility Users		
SFY	Actual	Projected
2004	24,694	25,469
2005	25,677	24,500
2006	24,842	26,447
2007		25,000
2008		25,000
2009		25,000

Paid Patient Days		
SFY	Actual	Projected
2004	8.9 mil	9.2 mil
2005	8.9 mil	9.1 mil
2006	8.8 mil	9.0 mil
2007		8.8 mil
2008		8.8 mil
2009		8.9 mil

Average Per Diem Rate	
SFY	Actual
2004	\$103.12
2005	\$108.95
2006	\$107.95
2007	\$111.12
2008	\$114.12
2009	

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITIES								
Nursing Fac Per Diem Rate Incr - 1886054								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	26,470,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	26,470,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$26,470,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$10,000,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$16,470,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
HOME HEALTH-PACE									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	4,763,456	0.00	4,349,017	0.00	4,349,017	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	7,360,331	0.00	7,360,331	0.00	7,360,331	0.00	
HEALTH INITIATIVES	0	0.00	159,305	0.00	159,305	0.00	159,305	0.00	
TOTAL - PD	0	0.00	12,283,092	0.00	11,868,653	0.00	11,868,653	0.00	
TOTAL	0	0.00	12,283,092	0.00	11,868,653	0.00	11,868,653	0.00	
Medicaid Caseload Growth - 1886033									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	4,295	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	7,073	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	11,368	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	11,368	0.00	0	0.00	
FMAP - 1886035									
PROGRAM-SPECIFIC									
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	64,439	0.00	64,439	0.00	
TOTAL - PD	0	0.00	0	0.00	64,439	0.00	64,439	0.00	
TOTAL	0	0.00	0	0.00	64,439	0.00	64,439	0.00	
In-Home Rate Increase - 1886063									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	39,699	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	65,381	0.00	
TOTAL - PD	0	0.00	0	0.00	0	0.00	105,080	0.00	
TOTAL	0	0.00	0	0.00	0	0.00	105,080	0.00	
GRAND TOTAL	\$0	0.00	\$12,283,092	0.00	\$11,944,460	0.00	\$12,038,172	0.00	

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Home Health--PACE

Budget Unit: 90564C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	4,349,017	7,360,331	159,305	11,868,653
TRF				
Total	4,349,017	7,360,331	159,305	11,868,653
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	4,349,017	7,360,331	159,305	11,868,653
TRF				
Total	4,349,017	7,360,331	159,305	11,868,653
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)

2. CORE DESCRIPTION

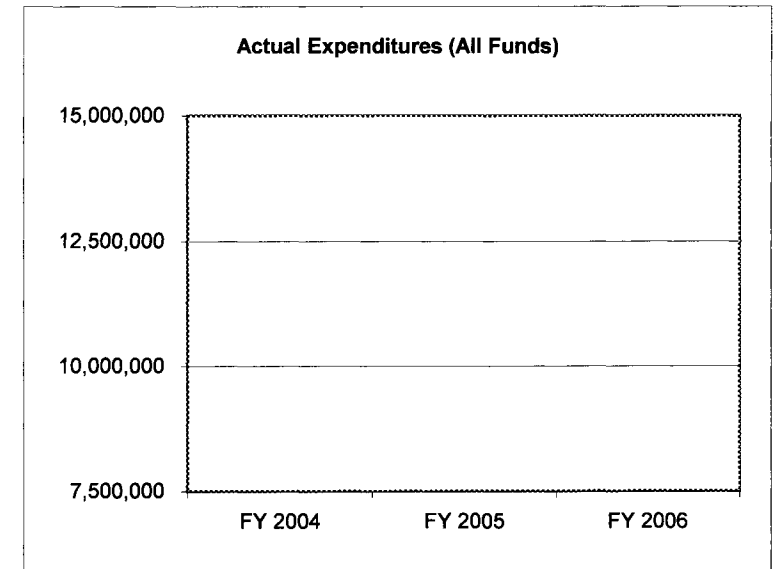
This core request is for ongoing funding for payments for services provided through the Home Health and PACE programs. These programs are designed to help a Medicaid recipient remain in their home instead of seeking institutional care.

3. PROGRAM LISTING (list programs included in this core funding)

Home Health Services and Programs for All-inclusive Care for the Elderly (PACE)

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	0	0	0	12,283,092
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	0	0	0	N/A
Actual Expenditures (All Funds)	0	0	0	N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A
			(1)	(2)



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Funding for the Home and Community Based program was transferred to DHSS in FY 2006.

(2) The Home Health and Pace programs were transferred back to DSS/DMS in FY 2007. These programs are not managed by DHSS.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
HOME HEALTH-PACE

5. CORE RECONCILIATION DETAIL

				Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES										
				PD	0.00	4,763,456	7,360,331	159,305	12,283,092	
				Total	0.00	4,763,456	7,360,331	159,305	12,283,092	
DEPARTMENT CORE ADJUSTMENTS										
1x Expenditures	601	1797	PD	0.00	(350,000)		0	0	(350,000)	One-time core reduction PACE Program Increase
Core Reduction	1705	1797	PD	0.00	(64,439)		0	0	(64,439)	FMAP Adjustment
NET DEPARTMENT CHANGES					0.00	(414,439)	0	0	(414,439)	
DEPARTMENT CORE REQUEST										
				PD	0.00	4,349,017	7,360,331	159,305	11,868,653	
				Total	0.00	4,349,017	7,360,331	159,305	11,868,653	
GOVERNOR'S RECOMMENDED CORE										
				PD	0.00	4,349,017	7,360,331	159,305	11,868,653	
				Total	0.00	4,349,017	7,360,331	159,305	11,868,653	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOME HEALTH-PACE								
CORE								
PROGRAM DISTRIBUTIONS	0	0.00	12,283,092	0.00	11,868,653	0.00	11,868,653	0.00
TOTAL - PD	0	0.00	12,283,092	0.00	11,868,653	0.00	11,868,653	0.00
GRAND TOTAL	\$0	0.00	\$12,283,092	0.00	\$11,868,653	0.00	\$11,868,653	0.00
GENERAL REVENUE	\$0	0.00	\$4,763,456	0.00	\$4,349,017	0.00	\$4,349,017	0.00
FEDERAL FUNDS	\$0	0.00	\$7,360,331	0.00	\$7,360,331	0.00	\$7,360,331	0.00
OTHER FUNDS	\$0	0.00	\$159,305	0.00	\$159,305	0.00	\$159,305	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Home Health--PACE

Program is found in the following core budget(s): Home Health--PACE

1. What does this program do?

PROGRAM SYNOPSIS: Funds Home Health services and PACE. These programs help Medicaid recipients remain in their homes instead of seeking institutional care.

The programs that make up this appropriation are: Home Health and PACE. A brief description of the Home Health and PACE programs follows.

Home Health - Home Health services provide primarily medically oriented treatment or supervision, on an intermittent basis, to homebound individuals with an acute illness which can be therapeutically managed at home. The care follows a written plan of treatment established and reviewed every 62 days by a physician. Services included in the home health benefit are skilled nursing, home health aide, physical, occupational and speech therapies, and supplies.

Home health services are reimbursed on a per visit basis. A visit is a personal contact for a period of time, not to exceed three hours in a client's home. Payment for the visit is the lower of: the provider's actual billed charge; the Medicare rate in effect as of the date of service; or the State Medicaid agency established capped amount. The current Medicaid cap is \$62.79. The cap was increased by \$1.00 (from \$61.79) in FY 07. The Home Health program is a mandatory program, added to the Medicaid program in July 1972, serving eligibles throughout the state.

PACE - The goal of the PACE program is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and supports to the individual while in their home and community. In other words, the PACE program helps the participant stay as independent as possible. The PACE organization is the individual's sole source provider, guaranteeing access to services but not to a specific provider.

The PACE organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week in an adult day health center setting. All medical services the individual requires while enrolled in the PACE program are the financial responsibility of the PACE provider.

PACE combines adult day settings, home care, interdisciplinary teams, transportation systems, and capitated payment systems so that providers can respond to the unique needs of each frail, elderly individual served.

The Missouri Department of Social Services, the Division of Medical Services, is the State administering agency for the PACE Program.

To be eligible to enroll in the PACE program, individuals must be at least 55 years old, live in St. Louis City or St. Louis County, have been certified by the Missouri Department of Health and Senior Services to have met the nursing home level of care of 21 points or higher, and be recommended by the PACE staff for PACE program services as the best option for their care.

At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

Enrollment in the PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time. Eligibility to enroll in the PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. A potential PACE enrollee may, but is not required to be, entitled to Medicare Part A, enrolled under Medicare Part B, or eligible for Medicaid.

Attendance at the PACE Center is determined by the interdisciplinary team and based on the needs and preferences of the participants. Some participants attend every day and some only 2-3 times per week. The PACE organization provides transportation to and from the PACE Center each day the participant is scheduled to attend.

The rule that establishes the requirements for the PACE Program may be found in the Code of Federal Regulations at 42 CFR 460. There are no state regulations that govern the PACE Program at this time. The PACE program is not a federally mandated program. States have the option of providing PACE.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.168; Federal law: Social Security Act Section 1905(a)(24), 1905(a)(7) and 1915(c);
Federal Regulations: 42 CFR 440.170(f), 440.210, 440.130 and 440.180

Federal Regulations: Social Security Act Sections: 1894, 1905(a) and 1934; 42 CFR 460.

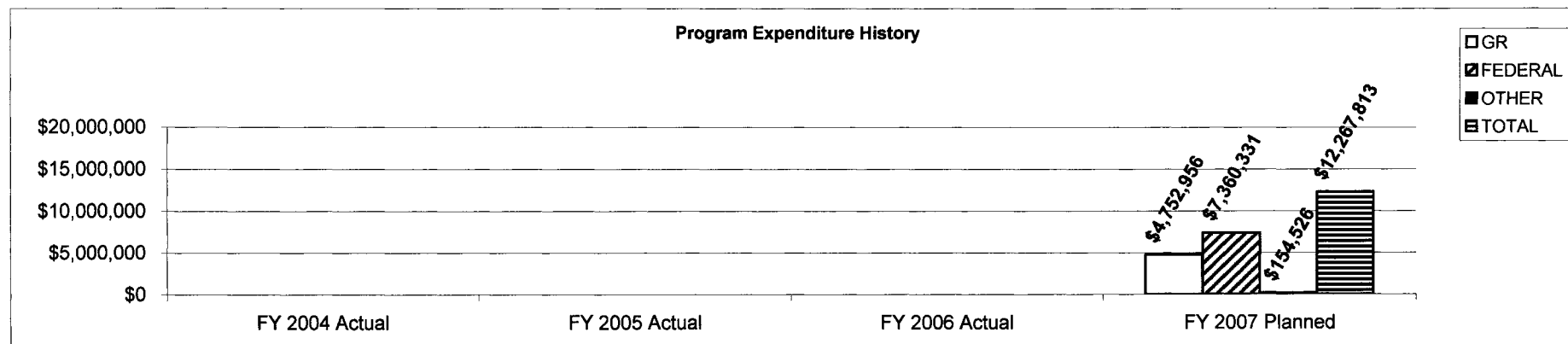
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Home Health is mandatory and PACE is optional.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



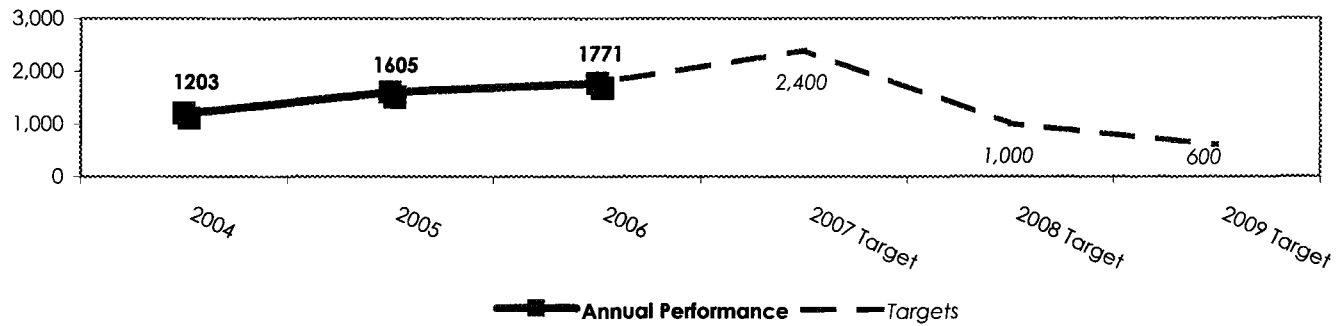
In FY06 Home Health and PACE funding was transferred to DHSS. In FY07, they were transferred back to DSS.

6. What are the sources of the "Other" funds?

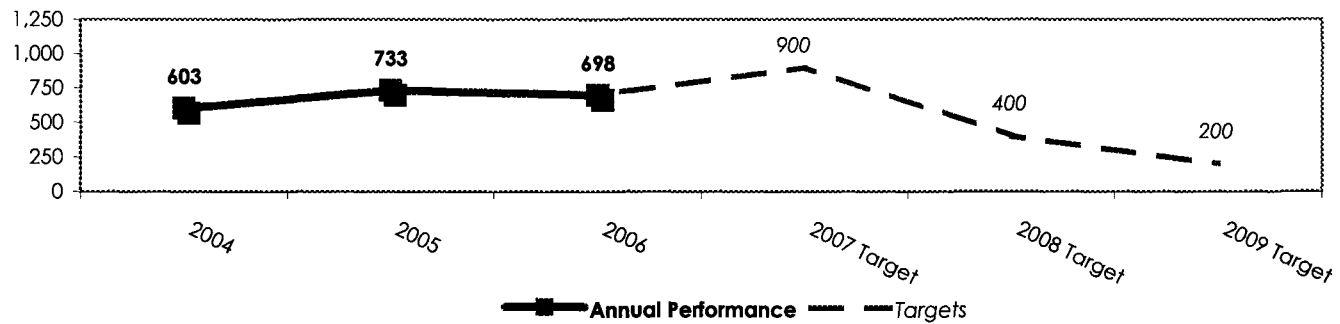
Health Initiatives Fund (0275).

7a. Provide an effectiveness measure.

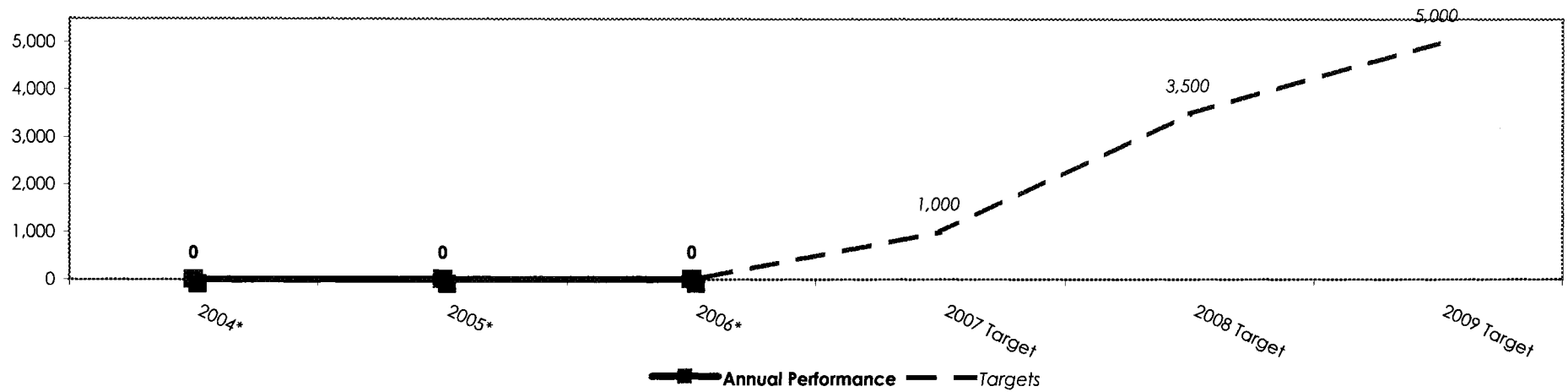
Medicaid/MC+ Recipients in a Disease Management Program



Medicaid Providers Participating in Disease Management

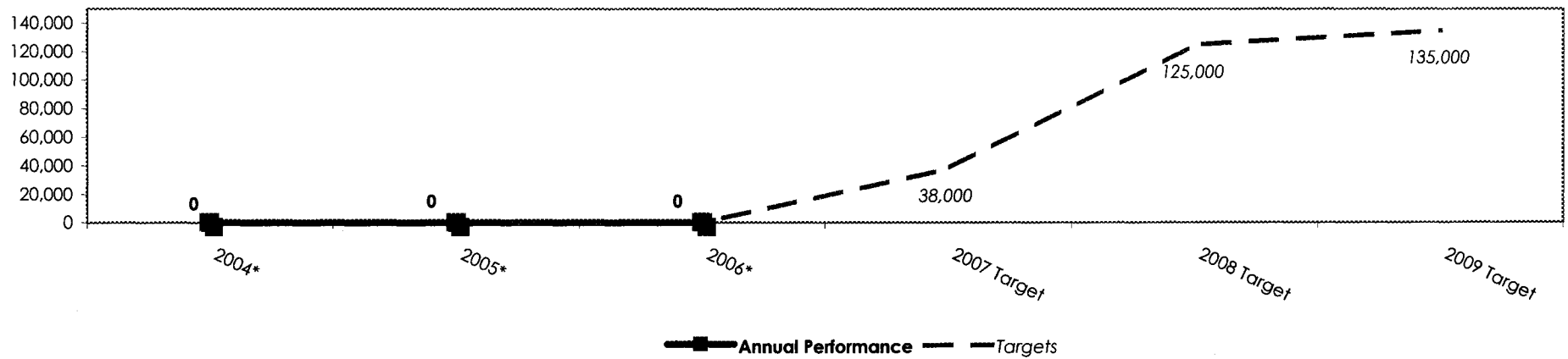


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Services are available to all Medicaid/MC+ eligibles, however, certain criteria (medical need or age requirement) must be met before recipients can receive services.

Average Monthly Users of Home Health Services		
SFY	Actual	Projected
2004	842	
2005	1,030	
2006	840	840
2007		840
2008		840
2009		840

Eligibles:

Recipients include dual eligibles, Medicaid eligibles and Medicare only eligibles.

PACE Recipients		
SFY	Actual	Projected
2004	175	
2005	164	
2006	162	
2007		172
2008		187
2009		197

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: In-Home Rate Increase

Budget Unit: 90564C
DI#: 1886063

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	39,699	65,381		105,080
TRF				
Total	39,699	65,381		105,080
FTE				0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Rate Increase	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funds increase in Home Health Services rate by \$0.50 per Medicaid cap.

This decision item provide for a cap increase of \$0.50 for direct care workers of in-home services. The current Medicaid cap is \$62.79. The cap was increased by \$1.00 (from \$61.79) in FY 07. Federal Authority is Social Security Act 1905(a) and 1915(c); 42 CFR 440.170, 440.210, 440.130, 440.180. State Authority is 208.152 RSMo.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

Home health services are reimbursed on a per visit basis. A visit is a personal contact for a period of time, not to exceed three hours in a client's home. Payment for the visit is the lower of: the provider's actual billed charge; the Medicare rate in effect as of the date of service; or the State Medicaid agency established capped amount. The current Medicaid cap is \$62.79. A \$0.50 cap increase is being recommended in this decision item. The fiscal impact for this decision item was based on the projected number of units of service for FY08 multiplied by the amount of increase. The SFY08 blended federal matching rate of 62.22% is used.

	Home Health Services
FY08 Projected Visits	210,159
	X
Proposed Rate Increase	\$0.50
Total Impact of \$1.00 Cap Increase	\$105,080

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

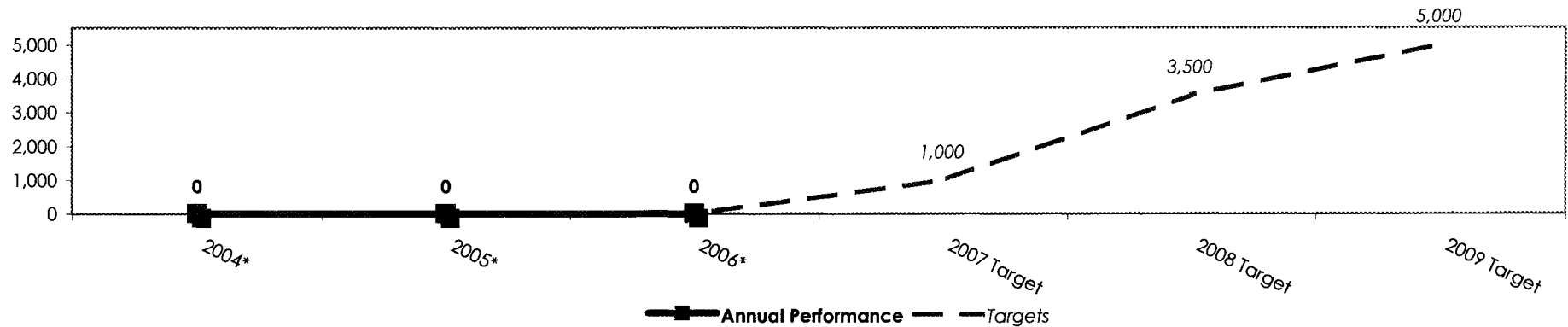
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	39,699		65,381				105,080		
Total PSD	39,699		65,381		0		105,080		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	39,699	0.0	65,381	0.0	0	0.0	105,080	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

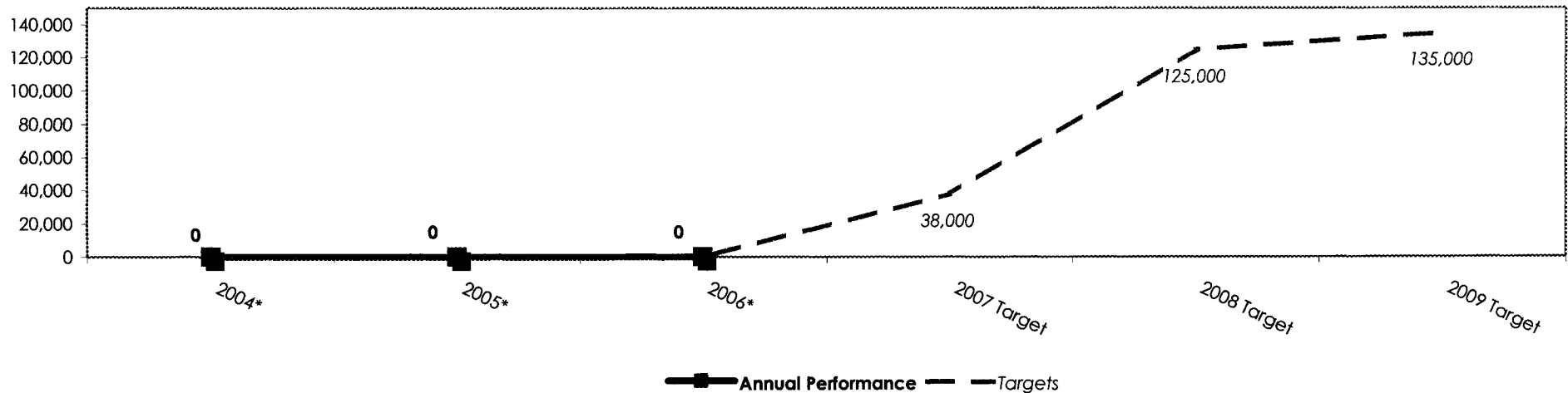
6a. Provide an effectiveness measure.

Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Average Monthly Users of Home Health Services		
SFY	Actual	Projected
2004	842	
2005	1,030	
2006	840	
2007		840
2008		840
2009		840

Eligibles:

Services are available to all Medicaid/MC+ eligibles, however, certain criteria (medical need or age requirement) must be met before recipients can receive services.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Request provider rate increases through the budget process.
- Identify, develop and analyze processes with stakeholders for the Medicaid seniors and disabled population to determine, measure and monitor recipient population health status.
- Identify, assess and monitor the impact of barriers to care resulting in increased hospitalizations by analyzing feedback from recipients and providers.
- Identify utilization baseline and population cohorts of high volume users and providers.
- Develop and utilize measures to analyze health outcomes.
- Implement time line for removal or amelioration of barriers to improved health status.
- Develop and implement a Comprehensive Chronic Illness Management program.
- Plan a process that would allow an individual discharged from the hospital to a nursing home (for recovery) to maintain existing community supports to ensure best possible chance of returning to the community.
- Work to make program modifications that allow an array of options which support consumer choice in community based service delivery.
- Maintain existing provider network of In-Home services providers.
- Analyze access geographically and by provider type.
- Process Medicaid provider enrollment applications in 45 days or less.
- Assure manuals are updated timely and on the internet.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOME HEALTH-PACE								
In-Home Rate Increase - 1886063								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	105,080	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	105,080	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$105,080	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$39,699	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$65,381	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	182,126	0.00	291,638	0.00	599,000	0.00	599,000	0.00
TITLE XIX-FEDERAL AND OTHER	560,805	0.00	351,000	0.00	599,000	0.00	599,000	0.00
HEALTH INITIATIVES	0	0.00	1,398	0.00	0	0.00	0	0.00
HFT-HEALTH CARE ACCT	0	0.00	5,964	0.00	0	0.00	0	0.00
TOTAL - EE	742,931	0.00	650,000	0.00	1,198,000	0.00	1,198,000	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	40,486,609	0.00	49,428,776	0.00	48,677,046	0.00	48,677,046	0.00
TITLE XIX-FEDERAL AND OTHER	67,307,689	0.00	85,850,994	0.00	85,090,452	0.00	85,090,452	0.00
HEALTH INITIATIVES	189,035	0.00	193,483	0.00	194,881	0.00	194,881	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	831,745	0.00	831,745	0.00
HFT-HEALTH CARE ACCT	831,745	0.00	825,781	0.00	0	0.00	0	0.00
TOTAL - PD	108,815,078	0.00	136,299,034	0.00	134,794,124	0.00	134,794,124	0.00
TOTAL	109,558,009	0.00	136,949,034	0.00	135,992,124	0.00	135,992,124	0.00
Medicaid Caseload Growth - 1886033								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	79,441	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	130,834	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	210,275	0.00	0	0.00
TOTAL	0	0.00	0	0.00	210,275	0.00	0	0.00
Hospice Rate Increase - 1886038								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	197,131	0.00	197,131	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	324,655	0.00	324,655	0.00
TOTAL - PD	0	0.00	0	0.00	521,786	0.00	521,786	0.00
TOTAL	0	0.00	0	0.00	521,786	0.00	521,786	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								

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DECISION ITEM SUMMARY

Budget Unit

Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	133,153	0.00	133,153	0.00
TOTAL - PD	0	0.00	0	0.00	133,153	0.00	133,153	0.00
TOTAL	0	0.00	0	0.00	133,153	0.00	133,153	0.00
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	2,752	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	4,531	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,283	0.00
TOTAL	0	0.00	0	0.00	0	0.00	7,283	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	321,979	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	530,267	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	852,246	0.00
TOTAL	0	0.00	0	0.00	0	0.00	852,246	0.00
GRAND TOTAL	\$109,558,009	0.00	\$136,949,034	0.00	\$136,857,338	0.00	\$137,506,592	0.00

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CORE DECISION ITEM

Department: Social Services
 Division: Medical Services
 Appropriation: Rehab and Specialty Services

Budget Unit: 90550C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	599,000	599,000		1,198,000
PSD	48,677,046	85,090,452	1,026,626	134,794,124
TRF				
Total	49,276,046	85,689,452	1,026,626	135,992,124
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Healthy Families Trust Fund- (0625)
 Health Initiatives Fund (HIF) (0275)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	599,000	599,000		1,198,000
PSD	48,677,046	85,090,452	1,026,626	134,794,124
TRF				
Total	49,276,046	85,689,452	1,026,626	135,992,124
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Healthy Families Trust Fund- (0625)
 Health Initiatives Fund (HIF) (0275)

2. CORE DESCRIPTION

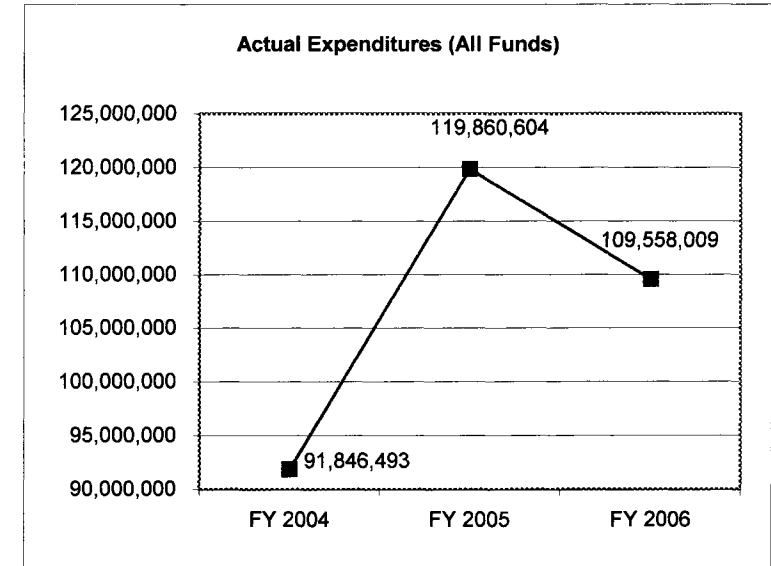
Funding provides Rehabilitation and Specialty services for the fee-for-service Title XIX population. In those regions of the state where MC+ Managed Care has been implemented enrollees have Rehab and Specialty services available through the MC+ Managed Care health plans.

3. PROGRAM LISTING (list programs included in this core funding)

Rehabilitation and Specialty Services

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	91,852,339	119,866,450	109,563,855	136,949,034
Less Reverted (All Funds)	(5,846)	(5,846)	(5,846)	N/A
Budget Authority (All Funds)	91,846,493	119,860,604	109,558,009	N/A
Actual Expenditures (All Funds)	91,846,493	119,860,604	109,558,009	N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A
	(2)	(3)	(4)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(2) FY 2004 appropriation reduced by \$8.4 million: \$4.8 million for recipient co-pays and \$3.6 million for limits and PAs for counseling/therapies. Expenditures of \$22,442,764 paid from the Supplemental Pool.

(3) FY 2005 appropriation reduced by \$9.4 million for elimination/reduction of specific services. Expenditures of \$21,784,471 paid from the Supplemental Pool.

(4) FY 2006 appropriation was reduced by \$13.4 million due to the elimination/reduction of services pursuant to SB 539. Expenditures were paid from other appropriations: \$22,835,407 paid from the Supplemental Pool; \$2,736,537 paid from Managed Care and \$243,750 from Pharmacy.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
REHAB AND SPECIALTY SERVICES

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES								
		EE	0.00	291,638	351,000	7,362	650,000	
		PD	0.00	49,428,776	85,850,994	1,019,264	136,299,034	
		Total	0.00	49,720,414	86,201,994	1,026,626	136,949,034	
DEPARTMENT CORE ADJUSTMENTS								
Core Reduction	1667 8204	PD	0.00	(311,215)	0	0	(311,215)	Core Cut -- MAWD
Core Reduction	1667 8205	PD	0.00	0	(512,542)	0	(512,542)	Core Cut -- MAWD
Core Reduction	1708 8204	PD	0.00	(133,153)	0	0	(133,153)	FMAP Adjustment
Core Reallocation	1172 8204	EE	0.00	307,362	0	0	307,362	
Core Reallocation	1172 3072	EE	0.00	0	0	(1,398)	(1,398)	
Core Reallocation	1172 8205	EE	0.00	0	248,000	0	248,000	
Core Reallocation	1172 5512	EE	0.00	0	0	(5,964)	(5,964)	
Core Reallocation	1172 8204	PD	0.00	(307,362)	0	0	(307,362)	
Core Reallocation	1172 5512	PD	0.00	0	0	5,964	5,964	
Core Reallocation	1172 3072	PD	0.00	0	0	1,398	1,398	
Core Reallocation	1172 8205	PD	0.00	0	(248,000)	0	(248,000)	
Core Reallocation	2121 5512	PD	0.00	0	0	(831,745)	(831,745)	Reallocation from #0640 to #0625
Core Reallocation	2121 3710	PD	0.00	0	0	831,745	831,745	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES			0.00	(444,368)	(512,542)	0	(956,910)	
DEPARTMENT CORE REQUEST								
		EE	0.00	599,000	599,000	0	1,198,000	

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**REHAB AND SPECIALTY SERVICES**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
DEPARTMENT CORE REQUEST							
	PD	0.00	48,677,046	85,090,452	1,026,626	134,794,124	
	Total	0.00	49,276,046	85,689,452	1,026,626	135,992,124	
GOVERNOR'S RECOMMENDED CORE							
	EE	0.00	599,000	599,000	0	1,198,000	
	PD	0.00	48,677,046	85,090,452	1,026,626	134,794,124	
	Total	0.00	49,276,046	85,689,452	1,026,626	135,992,124	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
CORE								
PROFESSIONAL SERVICES	742,931	0.00	650,000	0.00	1,198,000	0.00	1,198,000	0.00
TOTAL - EE	742,931	0.00	650,000	0.00	1,198,000	0.00	1,198,000	0.00
PROGRAM DISTRIBUTIONS	108,815,078	0.00	136,299,034	0.00	134,794,124	0.00	134,794,124	0.00
TOTAL - PD	108,815,078	0.00	136,299,034	0.00	134,794,124	0.00	134,794,124	0.00
GRAND TOTAL	\$109,558,009	0.00	\$136,949,034	0.00	\$135,992,124	0.00	\$135,992,124	0.00
GENERAL REVENUE	\$40,668,735	0.00	\$49,720,414	0.00	\$49,276,046	0.00	\$49,276,046	0.00
FEDERAL FUNDS	\$67,868,494	0.00	\$86,201,994	0.00	\$85,689,452	0.00	\$85,689,452	0.00
OTHER FUNDS	\$1,020,780	0.00	\$1,026,626	0.00	\$1,026,626	0.00	\$1,026,626	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Rehab and Specialty Services

Program is found in the following core budget(s): Rehab and Specialty Services

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for audiology, optometrics, durable medical equipment, ambulance, rehabilitation services, hospice, comprehensive day rehabilitation, disease management and diabetes self-management training for Medicaid/MC+ recipients. Unless otherwise noted, the rehabilitation and specialty services are covered only for eligibles who are under the age of 21, pregnant women, blind persons, or nursing facility residents.

Audiology/Hearing Aid - This program is intended only to provide hearing aids and related covered services. Persons eligible for reimbursement of Medicaid Hearing Aid Program services include eligible needy children or persons receiving Medicaid under a category of assistance for pregnant women or the blind. Covered services include: audiological testing, hearing aids, ear molds, hearing aid fitting, hearing aid dispensing/evaluation, post-fitting evaluation, post-fitting adjustments, and hearing aid repairs. All hearing aids and related services must have prior approval except audiometric testing, post-fitting evaluation, post-fitting adjustment, and repairs to hearing aids no longer under warranty. An audiologist consultant gives prior authorization for the claims.

A recipient is entitled to one new hearing aid and related services every four years. However, services for children under the EPSDT/HCY program are determined to be whatever is medically necessary. The EPSDT claims are reviewed by the consultant only if rejected by the computer system. Cost sharing, a charge for a small portion of the cost of services, applies to individuals age 18 and over with a few exceptions (foster care children and institutional residents).

Optical - The Medicaid Optometry program covers the following types of providers and services: (1) Optometrists, physicians (who can only bill for eyeglasses if they are enrolled as an optician), optometric clinics - eye examinations, eyeglasses, artificial eyes, and special ophthalmological services; and (2) Opticians - eyeglasses and artificial eyes. Prior authorization is needed for tints and some special tests. Recipients who are under the age of 21, pregnant, blind, or in a nursing facility are allowed an eye exam every twelve months unless there is a diopter change of .50. All other Medicaid/MC+ recipients over the age of 21 are allowed an eye exam every two years. Medicaid eligible recipients are allowed one pair of eye glasses every two years. Cost sharing, a charge for a small portion of the cost of the service, applies to individuals age 18 and over with a few exceptions (foster care children and institutional residents). An optometrist is used as a consultant for this program. The consultant reviews prescriptions that do not meet the program criteria and prices claims for special lenses and frames.

Durable Medical Equipment (DME) - The Missouri Medicaid Program reimburses qualified participating DME providers for certain items of durable medical equipment such as: prosthetics, diabetic supplies and equipment, oxygen and respiratory care equipment, ostomy supplies, wheelchairs, wheelchair accessories, labor and repair codes. These items must be for use in the recipient's home when ordered in writing by the recipient's physician or nurse practitioner and are covered for all Medicaid/MC+ recipients.

The following items are covered only for eligibles who are under the age of 21, pregnant women, blind persons, or nursing facility residents: apnea monitors, artificial larynx and related items, augmentative communications devices, canes, crutches, commodes, bed pans, urinals, CPAP devices, decubitus care equipment, hospital beds, side rails, humidifiers, BiPAP machines, IPPB machines, nebulizers, orthotics, patient lifts and trapeze, scooters, suction pumps, total parenteral nutrition mix, supplies and equipment, and walkers.

Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part, the equipment meets the definition of durable medical equipment or prosthesis, and the equipment is used in the recipient's home.

Even though a DME item may serve some useful medical purpose, consideration must be given by the physician and the DME supplier to what extent, if any, it is reasonable for Medicaid to pay for the item as opposed to another realistically feasible alternative pattern of care. Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the recipient. If two different items each meet the need of the recipient, the less expensive item must be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are not medically necessary, are not reimbursable.

Ambulance - Emergency medical transportation is provided under the ambulance program. Ambulance services are covered if they are emergency services and transportation is made to the nearest appropriate hospital. Certain specified non-emergency but medically necessary ambulance transports are also covered. Reimbursement is provided for the base charge (the lesser of the Medicaid maximum allowed amount or billed charge) for patient pickup and transportation to destination (mileage for transporting a patient beyond the five miles is not included in the base charge), mileage, and ancillary services related to emergency situations. Ambulance services can be provided through ground or air transportation (helicopter) if medically necessary. All Medicaid/MC+ recipients are eligible for ambulance services.

Rehabilitation Center - The rehabilitation center program pays for adaptive training of Medicaid recipients who have prosthetic/orthotic devices. Covered services include: comprehensive evaluation, stump conditioning, prosthetic training, and orthotic training, speech therapy for artificial larynx and occupational therapy related to the prosthetic/orthotic adaption. These procedures are covered by Medicaid even when the prosthetic/orthotic service was not provided through the Medicaid program.

Coverage of augmentative communication devices and training are covered and include the cost of the device, accessories, evaluation, and training. Training is also covered for the following prosthetic devices: artificial arms, artificial legs, artificial larynx, and orthotics.

Hospice - The hospice benefit is designed to meet the needs of patients with a life-limiting illness and to help their families cope with the problems and feelings related to this difficult time. Reimbursement is limited to qualified Medicaid enrolled hospice providers rendering services to terminally ill patients who have elected hospice benefits. After the recipient elects hospice services, the hospice provides for all care, supplies, equipment, and medicines related to the terminal illness. Medicaid reimburses the hospice provider who then reimburses the provider of the services if the services are not provided by the hospice provider.

Medicaid reimburses for routine home care, continuous home care, general inpatient, inpatient respite, and nursing home room and board, if necessary. Hospice rates are authorized by Section 1814 (l)(1)(C)(ii) of the Social Security Act and provide for an annual increase in the payment rates for hospice care services. The Medicaid rates are calculated based on the annual hospice rates established by Medicare. In addition, the Social Security Act also provides for an annual increase in the hospice cap amounts. Nursing Home room and board is reimbursed to the hospice provider at 95% of the nursing home rate on file. The hospice is responsible for paying the nursing home. All Medicaid/MC+ recipients are eligible for hospice services.

Comprehensive Day Rehabilitation - This program covers services for certain persons with disabling impairments as the result of a traumatic head injury. It provides intensive, comprehensive services designed to prevent and/or minimize chronic disabilities while restoring the individual to an optimal level of physical, cognitive, and behavioral function within the context of the person, family, and community.

The program emphasizes functional living skills, adaptive strategies for cognitive, memory or perceptual deficits, and appropriate interpersonal skills. These services help to train individuals so that the person can leave the rehabilitation center and re-enter society. Services are designed to maintain and improve the recipient's ability to function as independently as possible in the community. Services for this program must be provided in a free-standing rehabilitation center or in an acute hospital setting with space dedicated to head injury rehabilitation. Eligibility for this program is limited to individuals who are under the age of 21, pregnant women, blind persons or nursing home residents. These individuals must receive prior authorization from the Division of Medical Services. Reimbursement is made for either a full day or a half day of services.

Disease Management - This program was designed to improve the healthcare of patients who suffer from chronic conditions such as asthma, diabetes, heart failure, and depression. Physicians and pharmacists work as a team to achieve these primary goals: improve patient care, improve health outcomes, reduce inpatient hospitalization, reduce emergency room visits, lower total costs, and better educate patients and providers. All Medicaid/MC+ recipients are eligible for disease management services with chronic conditions as previously mentioned.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152; Federal law: Social Security Act Section 1905(a)(12) and (18), 1905(o); Federal regulation: 42 CFR 410.40, 418, 431.53, 440.60, 440.120, 440.130 and 440.170

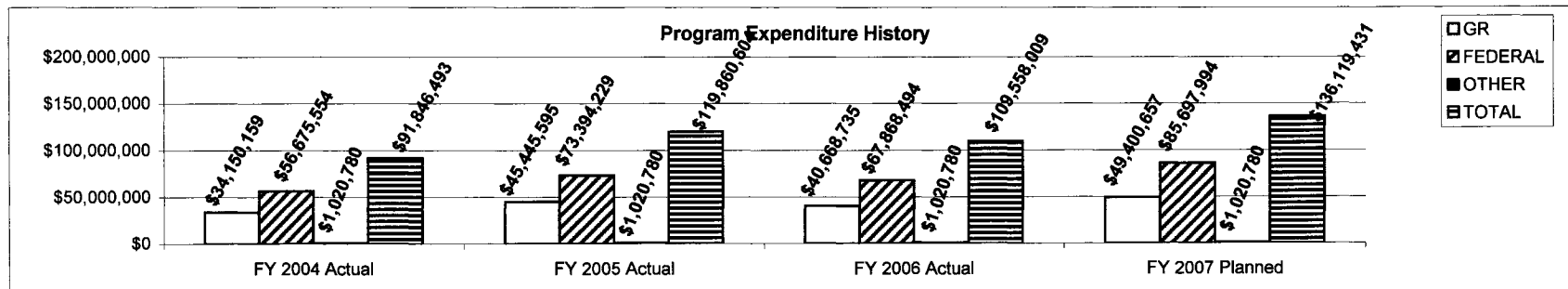
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

No for adults. Yes for children.

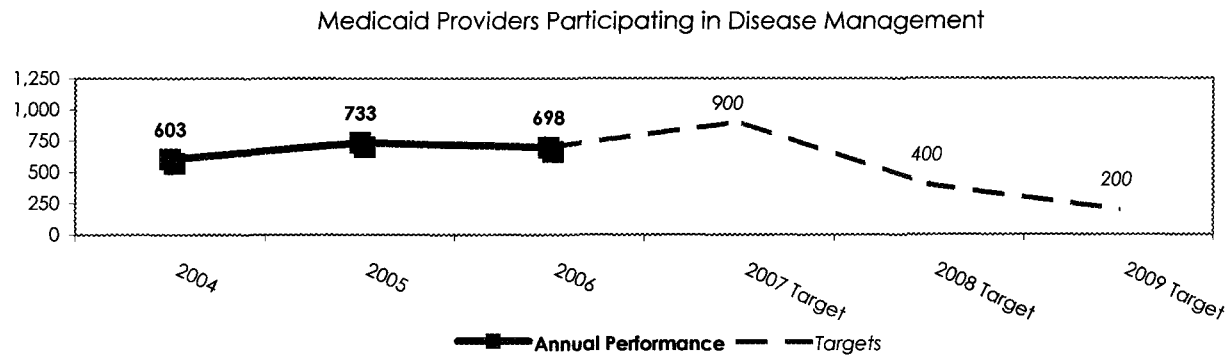
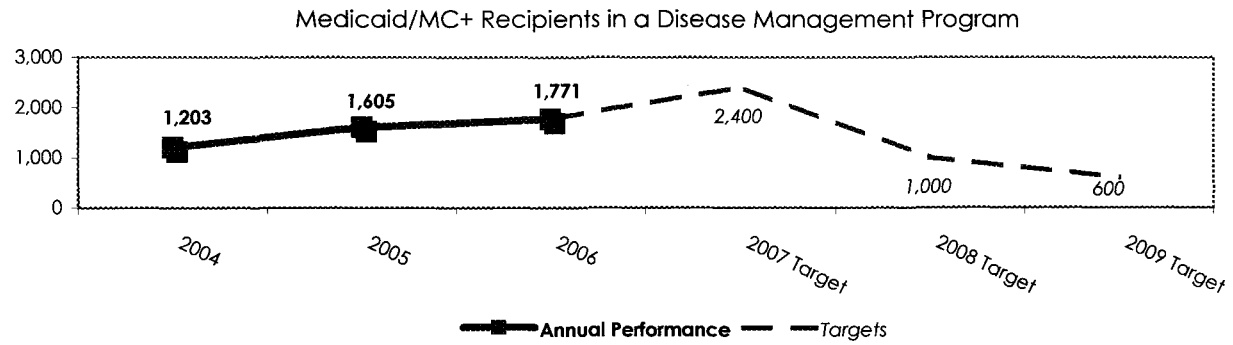
5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



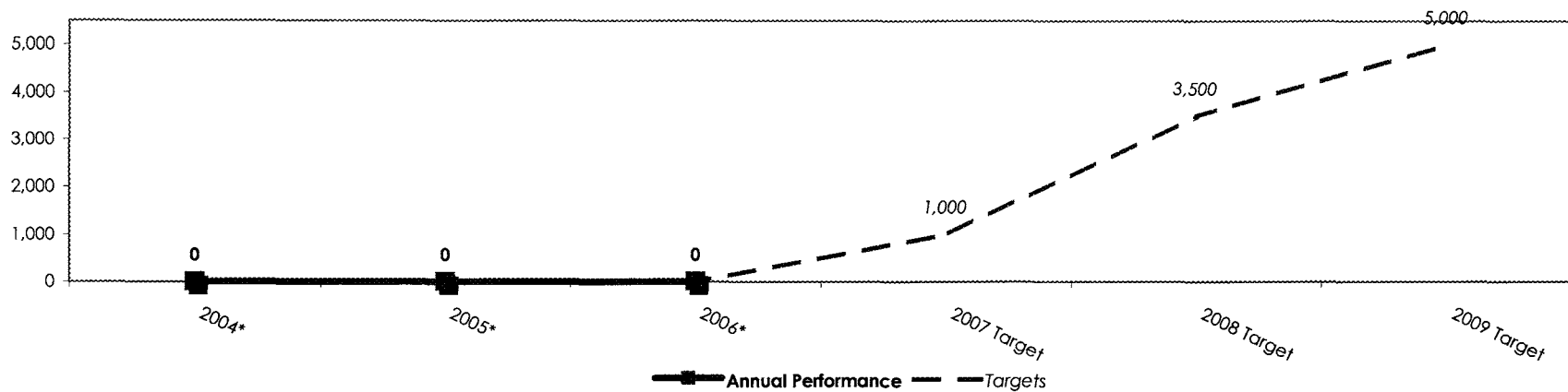
6. What are the sources of the "Other" funds?

Health Initiatives Fund (0275) and Healthy Families Trust Fund-Health Care Account (0640).

7a. Provide an effectiveness measure.

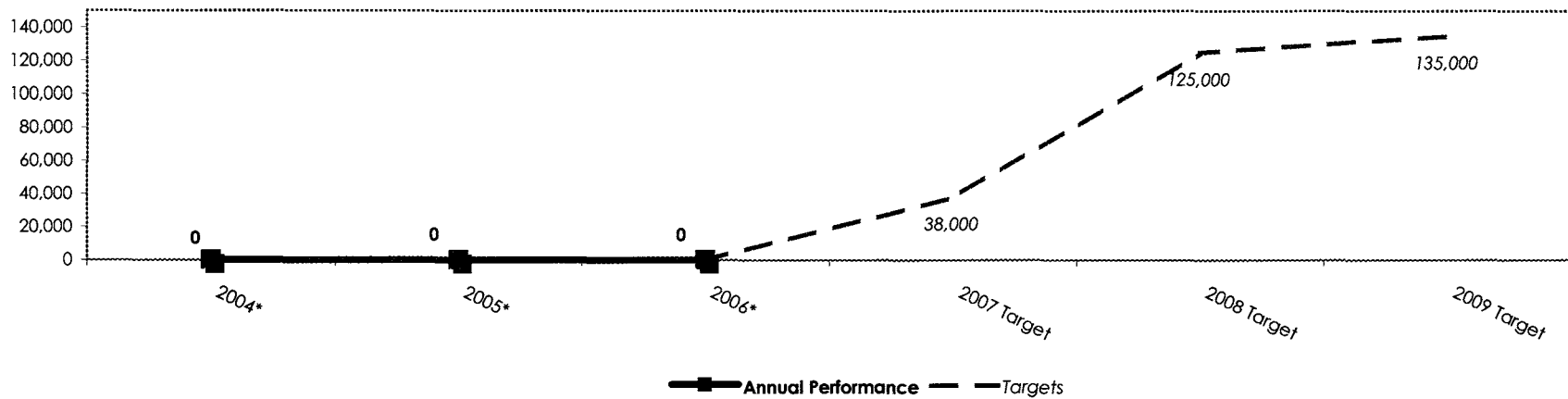


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Rehab and specialty services are available to certain Medicaid eligibles who are under the age of 21, pregnant, blind or reside in a nursing home. In those regions of the state where MC+ managed care has been implemented enrollees have rehab and specialty services available through the MC+ managed care health plans.

Average Monthly Users of Rehab and Specialty Services		
SFY	Actual	Projected
2004	47,918	
2005	51,178	53,524
2006	45,849	8,526
2007		45,391
2008		45,641
2009		45,641

Average Monthly DME Users		
SFY	Actual	Projected
2004	24,899	23,800
2005	25,327	28,534
2006	24,617	2,139
2007		23,031
2008		23,031
2009		23,031

Average Monthly Hospice Users		
SFY	Actual	Projected
2004	935	951
2005	1,317	1,038
2006	1,295	1,305
2007		1,305
2008		1,305
2009		1,305

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 19**

Department: Social Services
Division: Medicaid Services
DI Name: Hospice Rate Increase

Budget Unit: 90550C
DI#: 1886038

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	197,131	324,655		521,786
TRF				
Total	197,131	324,655		521,786
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	197,131	324,655		521,786
TRF				
Total	197,131	324,655		521,786
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding to apply annual hospice rate increase as established by Medicare.

The Medicaid hospice rates are calculated based on the annual hospice rates established under Medicare, Section 1814(j)(1)(ii). The Act provides for an annual increase in payment rates for hospice care services.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

Medicaid reimbursement for hospice care is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The four levels of care are routine home care, continuous home care, inpatient respite care, or general inpatient care. The rate paid for any day may vary, depending on the level of care furnished. Payment rates are adjusted for regional differences in wages.

A 3.4% increase is requested. This is the actual increase for FY 07. The rate of growth based on prior years was applied to actual FY 06 units to arrive at the FY 08 projected units of service. The projected units of services was multiplied by the projected increase in rates to arrive at the total need.

Hospice rates are adjusted in October which is the beginning of the federal fiscal year. This is three months into the state's fiscal year. This request includes the three months of FFY 07 that fall within SFY 08 - estimated impact of \$107,827. The twelve-months estimated increase for the FY 08 rate adjustment is \$551,945. This total is then divided by 9/12 to arrive at the SFY 08 impact of \$413,959. The total request for SFY 08 is \$521,786 (3 months totaling \$107,827 plus 9 months totaling \$413,959).

	Total	GR	Federal
July 2007 through Sept. 2007 Inc.	\$413,959	\$156,394	\$257,565
Oct. 2007 through June 2007 Inc.	\$107,827	\$40,737	\$67,090
Total	\$521,786	\$197,131	\$324,655

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	197,131		324,655				521,786		
Total PSD	197,131		324,655		0		521,786		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	197,131	0.0	324,655	0.0	0	0.0	521,786	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	197,131		324,655				521,786		
Total PSD	197,131		324,655		0		521,786		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	197,131	0.0	324,655	0.0	0	0.0	521,786	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b.

6c. Provide the number of clients/individuals served, if applicable.

Hospice Units of Service						
	FY 04	FY 05	FY 06	FY 07*	FY 08*	FY 09*
Routine Home Care	46,756	55,793	69,746	87,189	108,995	136,255
Continuous Home Care	225	259	1,639	1,887	2,173	2,502
Inpatient Respite	58	93	60	96	62	99
General Inpatient Care	285	244	313	402	516	662
NF Room and Board	311,324	385,676	495,841	637,453	819,510	1,053,562

*Projected

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Work with the Department of Health and Senior Services (DHSS) and Personal Independence Commission (PIC) to develop outreach materials and training on providing informed choice about long term care options.
- Make training available to hospital discharge planners regarding community options by incorporating it into the Informed Choice Training program.
- Plan a process that would allow an individual discharged from the hospital to a nursing home (for recovery) to maintain existing community supports to ensure best possible chance of returning to the community.
- Work to make program modifications that allow an array of options which support consumer choice in community based service delivery.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
REHAB AND SPECIALTY SERVICES								
Hospice Rate Increase - 1886038								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	521,786	0.00	521,786	0.00
TOTAL - PD	0	0.00	0	0.00	521,786	0.00	521,786	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$521,786	0.00	\$521,786	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$197,131	0.00	\$197,131	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$324,655	0.00	\$324,655	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	FTE
NON-EMERGENCY TRANSPORT									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	10,967,225	0.00	11,069,594	0.00	11,069,594	0.00	11,069,594	0.00	0.00
TITLE XIX-FEDERAL AND OTHER	20,189,561	0.00	24,442,963	0.00	24,230,651	0.00	24,230,651	0.00	0.00
TOTAL - PD	31,156,786	0.00	35,512,557	0.00	35,300,245	0.00	35,300,245	0.00	0.00
TOTAL	31,156,786	0.00	35,512,557	0.00	35,300,245	0.00	35,300,245	0.00	0.00
Medicaid Caseload Growth - 1886033									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	23,407	0.00	0	0.00	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	38,549	0.00	0	0.00	0.00
TOTAL - PD	0	0.00	0	0.00	61,956	0.00	0	0.00	0.00
TOTAL	0	0.00	0	0.00	61,956	0.00	0	0.00	0.00
NEMT Rate Increase - 1886039									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	729,090	0.00	729,090	0.00	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	2,010,397	0.00	2,010,397	0.00	0.00
TOTAL - PD	0	0.00	0	0.00	2,739,487	0.00	2,739,487	0.00	0.00
TOTAL	0	0.00	0	0.00	2,739,487	0.00	2,739,487	0.00	0.00
FMAP - 1886035									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	212,312	0.00	212,312	0.00	0.00
TOTAL - PD	0	0.00	0	0.00	212,312	0.00	212,312	0.00	0.00
TOTAL	0	0.00	0	0.00	212,312	0.00	212,312	0.00	0.00
Medical for Foster Children - 1886057									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	3,172	0.00	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	5,223	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	8,395	0.00
TOTAL	0	0.00	0	0.00	0	0.00	8,395	0.00
GRAND TOTAL	\$31,156,786	0.00	\$35,512,557	0.00	\$38,314,000	0.00	\$38,260,439	0.00

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CORE DECISION ITEM

Department: Social Services
 Division: Medical Services
 Appropriation: Non-Emergency Medical Transportation (NEMT)

Budget Unit: 90561C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	11,069,594	24,230,651		35,300,245
TRF				
Total	11,069,594	24,230,651		35,300,245
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	11,069,594	24,230,651		35,300,245
TRF				
Total	11,069,594	24,230,651		35,300,245
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

2. CORE DESCRIPTION

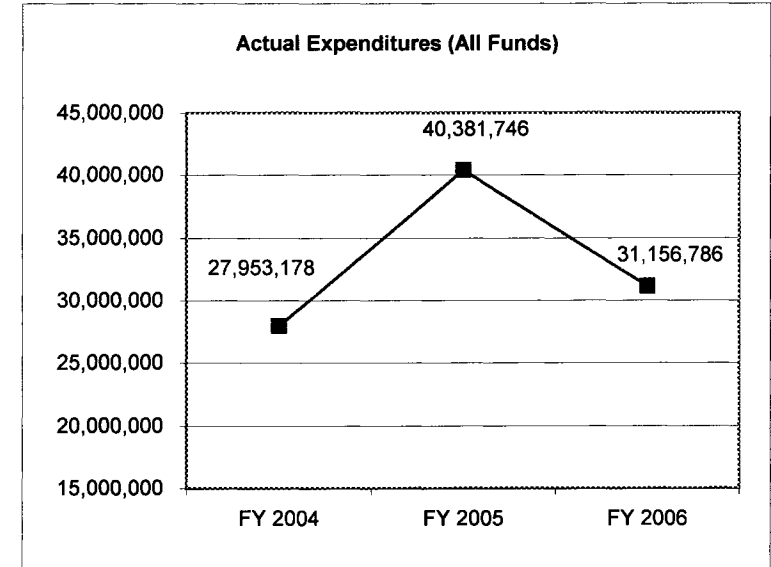
This core request is to provide funding for payments for non-emergency medical transportation.

3. PROGRAM LISTING (list programs included in this core funding)

Non-Emergency Medical Transportation (NEMT)

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	27,953,178	40,960,501	32,643,668	35,512,557
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	27,953,178	40,960,501	32,643,668	N/A
Actual Expenditures (All Funds)	27,953,178	40,381,746	31,156,786	N/A
Unexpended (All Funds)	0	578,755	1,486,882	N/A
Unexpended, by Fund:				
General Revenue	0	916	0	N/A
Federal	0	577,839	1,486,882	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Expenditures of \$13,677,899 were paid from the Supplemental Pool.

(2) Excess federal authority - funded as a program (60/40) but received administrative match (50/50).

(3) Lapse of \$1.5 million in Federal. Funded as a program (60/40) but received administrative match (50/50) first four months then received program match for the remainder of the year. Expenditures of \$5,560,655 were paid from the Supplemental Pool.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**NON-EMERGENCY TRANSPORT**

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
		PD		0.00	11,069,594	24,442,963	0	35,512,557	
		Total		0.00	11,069,594	24,442,963	0	35,512,557	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1709 5929	PD		0.00	0	(212,312)	0	(212,312)	FMAP Adjustment
NET DEPARTMENT CHANGES				0.00	0	(212,312)	0	(212,312)	
DEPARTMENT CORE REQUEST									
		PD		0.00	11,069,594	24,230,651	0	35,300,245	
		Total		0.00	11,069,594	24,230,651	0	35,300,245	
GOVERNOR'S RECOMMENDED CORE									
		PD		0.00	11,069,594	24,230,651	0	35,300,245	
		Total		0.00	11,069,594	24,230,651	0	35,300,245	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
CORE								
PROGRAM DISTRIBUTIONS	31,156,786	0.00	35,512,557	0.00	35,300,245	0.00	35,300,245	0.00
TOTAL - PD	31,156,786	0.00	35,512,557	0.00	35,300,245	0.00	35,300,245	0.00
GRAND TOTAL	\$31,156,786	0.00	\$35,512,557	0.00	\$35,300,245	0.00	\$35,300,245	0.00
GENERAL REVENUE	\$10,967,225	0.00	\$11,069,594	0.00	\$11,069,594	0.00	\$11,069,594	0.00
FEDERAL FUNDS	\$20,189,561	0.00	\$24,442,963	0.00	\$24,230,651	0.00	\$24,230,651	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Non-Emergency Medical Transportation (NEMT)

Program is found in the following core budget(s): Non-Emergency Medical Transportation (NEMT)

1. What does this program do?

PROGRAM SYNOPSIS: Provides payments for non-emergency medical transportation for Medicaid recipients who do not have access to free transportation to scheduled Medicaid-covered services.

The purpose of the NEMT program is to ensure non-emergency medical transportation to Missouri Medicaid recipients who do not have access to free appropriate transportation (can transport themselves or can use free community resources or other free programs) to scheduled Medicaid-covered services. The recipient is to be provided with the most appropriate mode of transportation. As of November 2005, the service is provided as a direct state plan service through a Prepaid Ambulatory Health Plan (PAHP). The state contracts with a statewide broker and pays monthly capitation payments for each NEMT eligible.

Missouri's program utilizes and builds on the existing transportation networks in the state. While the fee-for-service Medicaid NEMT program is administered through a PAHP, the Managed Care providers are required to include NEMT in their benefit package. Under the PAHP contract, the state is divided into regions/areas.

Where appropriate and possible, the DMS enters into cooperative agreements to provide matching Medicaid funds for state and local general revenue already being used to transport Medicaid eligible individuals to medical services. Recipients are encouraged to use public transportation when available. When they do so, the payments are made by public entities on a per trip basis. By working with existing governmental entities and established transportation providers, NEMT is provided in a cost-effective manner and governmental agencies are able to meet the needs of their constituency.

DMS works with the following state agencies to provide federal matching funds for general revenue used for NEMT services: the Children's Division for children in state care and custody, DHSS Division of Senior Services with the Area Agencies on Aging (AAA), the Department of Health Head Injury Program, and school districts.

The current NEMT program is subject to an approved federal 1915(b) waiver. The waiver includes cost-effectiveness estimates. The waiver requires an independent evaluation of the waiver with respect to access to care, quality of services, and cost effectiveness that must be submitted to the Centers for Medicare and Medicaid Services. At the end of the waiver period, or at prescribed intervals within the waiver period, the state must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. DMS is currently pursuing the move of the NEMT broker system from the 1915(b) waiver to a state plan service due to change in the federal allowances which will accommodate a brokerage system without a 1915(b) waiver. This change does not affect current policy or operations.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, Federal regulation: 42 CFR 431.53 and 440.170

3. Are there federal matching requirements? If yes, please explain.

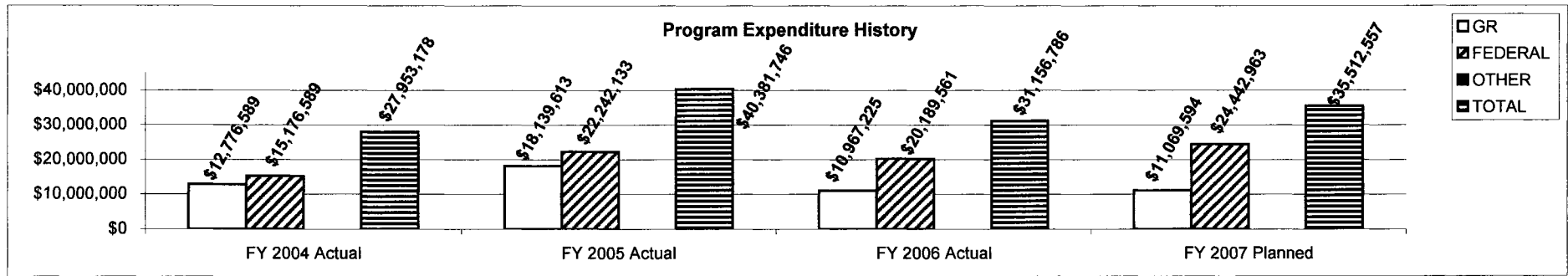
Services provided through the PAHP receive a federal medical assistance percentage (FMAP) on program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

Services provided through public entities use state and local general revenue to transport Medicaid eligible individuals. DMS provides payment of the federal share for these services. These expenditures earn a 50% federal match.

4. Is this a federally mandated program? If yes, please explain.

Yes, state Medicaid programs must assure availability of medically necessary transportation.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

Provider	NEMT Payments			
	FY 2003	FY 2004	FY 2005	FY 2006
Private Contractor - MTM	\$ 30,520,787	\$38,006,750	\$36,277,873	\$17,088,584
Private Contractor - Logisticare				\$15,087,581
Public Entities (Federal Only)	\$ 2,361,145	\$ 3,624,327	\$ 4,103,875	\$ 4,542,243
Total	\$32,881,932	\$41,631,077	\$40,381,748	\$36,718,408

Average Number of Trip (per Month)		
Provider	SFY	Trips
MTM	2004	65,348
MTM	2005	60,022
MTM	2006 *	60,842
Logisticare	2006**	85,852
Logisticare	2007***	83,555

* Four month average

** Eight month average

*** Two month average

Logisticare trips are net authorized.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Non-emergency medical transportation is available to all Medicaid eligibles except SCHIP and 1115 adults. NEMT is included in MC+ Managed Care health benefits. *Prior to November, 2005 payments were made only for services that were provided. Since then capitated payments are made for all eligible recipients. The number of users in FY 2006 is a four month average of the number of people for whom a NEMT trip was provided. The number of eligibles reported in FY 2006 is an average monthly number of people for whom capitated payments were made.

Excluding trips provided by FSD, 274,000 trips are estimated to be paid for by public entities in FY 08.

Average Monthly NEMT Users		
SFY	Actual	Projected
2004	12,074	
2005	12,182	
*2006	12,626	

Average Monthly NEMT Eligibles		
SFY	Actual	Projected
*2006	419,558	
2007		460,204
2008		462,419
2009		464,592

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 20**

Department: Social Services
Division: Medical Services
DI Name: NEMT Rate Increase

Budget Unit: 90561C
DI#: 1886039

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	729,090	2,010,397		2,739,487
TRF				
Total	729,090	2,010,397		2,739,487
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	729,090	2,010,397		2,739,487
TRF				
Total	729,090	2,010,397		2,739,487
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

This funding is needed to apply an inflation cost and utilization increase (7%) as required by CMS in developing actuarially sound rates. A 14% increase is needed to fund the services provided by public entities. State statutory authority for this program is found in RSMo. 208.152 and federal regulatory authority is found in 42 CFR 431.53 and 440.170.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

A statewide average increase (7%) for NEMT services was developed by the Division of Medical Services' actuary and is in accordance with actuarially sound standards set by the CMS. This increase was applied to the projected number of eligibles to arrive at the total increase of \$1,929,831 for this portion of the program.

	FY 07 Rate	FY 08 Rate	Increase	Projected FTE	Total
ABD Region 1	\$6.90	\$7.38	\$0.48	682,460	\$327,581
ABD Region 2	\$6.70	\$7.17	\$0.47	387,037	\$181,907
ABD Region 3	\$11.49	\$12.29	\$0.80	1,556,193	\$1,244,954
MAFCP All Regions	\$0.82	\$0.88	\$0.06	2,923,150	\$175,389
					<u>\$1,929,831</u>

The increase requested for funding NEMT services provided by public entities is based on the projected need found by calculating the difference between a three year average of the amount of funds certified by the various public entities to provide these services and the amount that was actually paid. The total amount requested for this portion of the program is \$809,656.

Projected Amounts Certified by Public Entities	\$7,172,811
Projected Amount Paid (90.06% - last 2 yr average)	\$6,460,100
FY 07 Appropriation - Public Entities	\$5,650,444
Request	<u>\$809,656</u>

	Total	GR	Federal
Direct State Plan Srv	\$1,929,831	\$729,090	\$1,200,741
Public Entities	<u>\$809,656</u>		<u>\$809,656</u>
Total	<u>\$2,739,487</u>	<u>\$729,090</u>	<u>\$2,010,397</u>

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	729,090		2,010,397				2,739,487		
Total PSD	729,090		2,010,397		0		2,739,487		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	729,090	0.0	2,010,397	0.0	0	0.0	2,739,487	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	729,090		2,010,397				2,739,487		
Total PSD	729,090		2,010,397		0		2,739,487		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	729,090	0.0	2,010,397	0.0	0	0.0	2,739,487	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

NEMT Payments				
Provider	FY 2003	FY 2004	FY 2005	FY 2006
Private Contractor - MTM	\$30,520,787	\$38,006,750	\$36,277,873	\$17,088,584
Private Contractor - Logisticare	\$0	\$0	\$0	\$15,087,581
Public Entities (Federal Only)	\$2,361,145	\$3,624,327	\$4,103,875	\$4,542,243
Total	\$32,881,932	\$41,631,077	\$40,381,748	\$36,718,408

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Average Monthly NEMT Users		
SFY	Actual	Projected
2004	12,074	
2005	12,182	
*2006	12,626	

Average Monthly NEMT Eligibles		
SFY	Actual	Projected
*2006	419,558	
2007		460,204
2008		462,419
2009		464,592

Non-emergency medical transportation is available to all Medicaid eligibles except SCHIP and 1115 adults. NEMT is included in MC+ Managed Care health benefits. *Prior to November, 2005 payments were made only for services that were provided. Since then capitated payments are made for all eligible recipients. The number of users in FY 2006 is a four month average of the number of people for whom a NEMT trip was provided. The number of eligibles reported in FY 2006 is an average monthly number of people for whom capitated payments were made.

Excluding trips provided by FSD, 274,000 trips are estimated to be paid for by public entities in FY 08.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NON-EMERGENCY TRANSPORT								
NEMT Rate Increase - 1886039								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	2,739,487	0.00	2,739,487	0.00
TOTAL - PD	0	0.00	0	0.00	2,739,487	0.00	2,739,487	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$2,739,487	0.00	\$2,739,487	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$729,090	0.00	\$729,090	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$2,010,397	0.00	\$2,010,397	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	162,418,851	0.00	173,972,073	0.00	173,972,073	0.00	173,972,073	0.00
TITLE XIX-FEDERAL AND OTHER	511,339,232	0.00	567,439,782	0.00	567,382,617	0.00	567,382,617	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	109,064,837	0.00	109,065,009	0.00	109,065,009	0.00	109,065,009	0.00
MEDICAID MNG CARE ORG REIMB AL	42,346,713	0.00	47,918,434	0.00	45,912,625	0.00	45,912,625	0.00
HEALTH INITIATIVES	8,677,113	0.00	9,055,080	0.00	9,055,080	0.00	9,055,080	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	4,447,110	0.00	4,447,110	0.00
HFT-HEALTH CARE ACCT	4,282,090	0.00	4,447,110	0.00	0	0.00	0	0.00
TOTAL - PD	838,128,836	0.00	911,897,488	0.00	909,834,514	0.00	909,834,514	0.00
TOTAL	838,128,836	0.00	911,897,488	0.00	909,834,514	0.00	909,834,514	0.00
Medicaid Caseload Growth - 1886033								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	2,005,901	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,303,525	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	5,309,426	0.00	0	0.00
TOTAL	0	0.00	0	0.00	5,309,426	0.00	0	0.00
Managed Care Rate Increase - 1886040								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	25,614,829	0.00	25,614,829	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	42,185,141	0.00	42,185,141	0.00
TOTAL - PD	0	0.00	0	0.00	67,799,970	0.00	67,799,970	0.00
TOTAL	0	0.00	0	0.00	67,799,970	0.00	67,799,970	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	57,165	0.00	57,165	0.00
TOTAL - PD	0	0.00	0	0.00	57,165	0.00	57,165	0.00
TOTAL	0	0.00	0	0.00	57,165	0.00	57,165	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	166,530	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	274,260	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	440,790	0.00
TOTAL	0	0.00	0	0.00	0	0.00	440,790	0.00
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	7,248,738	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	11,943,263	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	19,192,001	0.00
TOTAL	0	0.00	0	0.00	0	0.00	19,192,001	0.00
Provider Tax GR Replacement - 1886066								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	2,005,809	0.00	2,005,809	0.00
TOTAL - PD	0	0.00	0	0.00	2,005,809	0.00	2,005,809	0.00
TOTAL	0	0.00	0	0.00	2,005,809	0.00	2,005,809	0.00
GRAND TOTAL	\$838,128,836	0.00	\$911,897,488	0.00	\$985,006,884	0.00	\$999,330,249	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Managed Care

Budget Unit: 90551C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	173,972,073	567,382,617	168,479,824	909,834,514
TRF				
Total	173,972,073	567,382,617	168,479,824	909,834,514

FTE 0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Health Initiatives Fund (HIF) (0275)
Medicaid Managed Care Organization Reimb Allowance Fund (0160)
Federal Reimbursement Allowance Fund (FRA) (0142)
Healthy Families Trust Fund (0625)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	173,972,073	567,382,617	168,479,824	909,834,514
TRF				
Total	173,972,073	567,382,617	168,479,824	909,834,514

FTE 0.00

Est. Fringe	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Health Initiatives Fund (HIF) (0275)
Medicaid Managed Care Organization Reimb Allowance Fund (0160)
Federal Reimbursement Allowance Fund (FRA) (0142)
Healthy Families Trust Fund (0625)

2. CORE DESCRIPTION

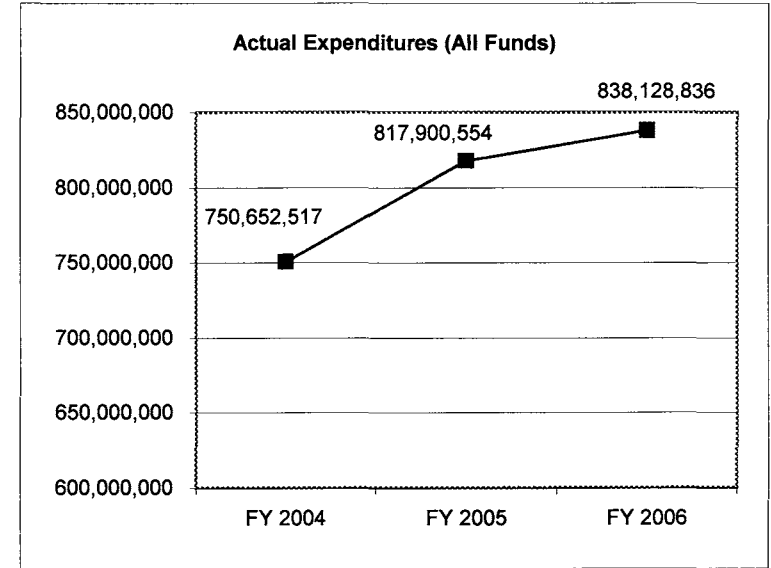
This core request is for the continued funding of the Managed Care Medicaid program to provide health care services to the managed care Medicaid population.

3. PROGRAM LISTING (list programs included in this core funding)

Managed Care

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	751,740,368	824,737,006	890,532,310	911,897,488
Less Reverted (All Funds)	(248,125)	(253,924)	(98,241)	N/A
Budget Authority (All Funds)	751,492,243	824,483,082	890,434,069	N/A
Actual Expenditures (All Funds)	750,652,517	817,900,554	838,128,836	N/A
Unexpended (All Funds)	839,726	6,582,528	52,305,233	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	156,634	6,582,528	42,958,126	N/A
Other	683,092	0	9,347,107	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Lapse of \$683,092 in FRA. There was no cash to support this authority. Expenditures of \$8,675,665 paid from the Supplemental Pool.

(2) Expenditures of \$4,447,408 (GR) paid from the Supplemental Pool.

(3) Lapse in Other: \$98,241 in FRA; \$165,020 in HFT; and, \$9.2 million in MC-FRA. FY 2006 is the first year of the managed care tax so there was only 11 months of collections. Therefore, there was not enough cash to support the MC-FRA funding authority.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

MANAGED CARE

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			PD	0.00	173,972,073	567,439,782	170,485,633	911,897,488	
			Total	0.00	173,972,073	567,439,782	170,485,633	911,897,488	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1710 1784		PD	0.00	0	(57,165)	0	(57,165)	FMAP Adjustment
Core Reduction	3245 0803		PD	0.00	0	0	(2,005,809)	(2,005,809)	Core Cut - Provider Tax Cap Reduction
Core Reallocation	2120 5513		PD	0.00	0	0	(4,447,110)	(4,447,110)	Reallocation from #0640 to #0625
Core Reallocation	2120 3711		PD	0.00	0	0	4,447,110	4,447,110	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES				0.00	0	(57,165)	(2,005,809)	(2,062,974)	
DEPARTMENT CORE REQUEST									
			PD	0.00	173,972,073	567,382,617	168,479,824	909,834,514	
			Total	0.00	173,972,073	567,382,617	168,479,824	909,834,514	
GOVERNOR'S RECOMMENDED CORE									
			PD	0.00	173,972,073	567,382,617	168,479,824	909,834,514	
			Total	0.00	173,972,073	567,382,617	168,479,824	909,834,514	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MANAGED CARE								
CORE								
PROGRAM DISTRIBUTIONS	838,128,836	0.00	911,897,488	0.00	909,834,514	0.00	909,834,514	0.00
TOTAL - PD	838,128,836	0.00	911,897,488	0.00	909,834,514	0.00	909,834,514	0.00
GRAND TOTAL	\$838,128,836	0.00	\$911,897,488	0.00	\$909,834,514	0.00	\$909,834,514	0.00
GENERAL REVENUE	\$162,418,851	0.00	\$173,972,073	0.00	\$173,972,073	0.00	\$173,972,073	0.00
FEDERAL FUNDS	\$511,339,232	0.00	\$567,439,782	0.00	\$567,382,617	0.00	\$567,382,617	0.00
OTHER FUNDS	\$164,370,753	0.00	\$170,485,633	0.00	\$168,479,824	0.00	\$168,479,824	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Managed Care

Program is found in the following core budget(s): Managed Care

1. What does this program do?

PROGRAM SYNOPSIS: Provides funding for capitation payments to managed care plans on behalf of MC+ eligibles enrolled in managed care.

The Division of Medical Services (DMS) operates an HMO-style managed care program, MC+ Managed Care. Health plans contract with the state and are paid a monthly capitation payment for providing services for each enrollee. Participation in MC+ Managed Care is mandatory for certain Medicaid eligibility groups within the regions in operation. The mandatory groups are: Medical Assistance for Families-Adults and Children, Medicaid for Children, Refugees, Medicaid for Pregnant Women, Children in State Care and Custody, and 1115 Waiver Children (MC+ for Kids). Those recipients who receive Supplemental Security Income (SSI), meet the SSI medical disability definition, or get adoption subsidy benefits may stay in MC+ Managed Care or may choose to receive services on a fee-for-service basis. The MC+ Managed Care program is currently operating in the Eastern Region since September 1, 1995, in the Central Region since March 1, 1996, and in the Western Region since January 1, 1997.

The MC+ Managed Care program is subject to an approved federal 1915(b) waiver and an approved 1115 waiver. The waivers include a cost-effectiveness estimate. Each waiver requires an independent evaluation of the waiver with respect to access to care, quality of services, and cost-effectiveness that must be submitted to the Centers for Medicare and Medicaid Services. At the end of the waiver period, or at prescribed intervals within the waiver period, the state must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance.

Objectives of the MC+ Managed Care program include cost effectiveness, quality of care, contract compliance, and member satisfaction.

Services: In MC+ Managed Care, most enrollees receive all the services that the fee-for-service program offers. MC+ Managed Care enrollees eligible under the 1115 waiver receive a package of services that are detailed in the 1115 Waiver program description. Examples of services included in the capitation payment paid to health plans are: hospital, physician, pharmacy, emergency medical services, EPSDT services, family planning services, dental, optical, audiology, personal care, adult day health care and mental health services. Certain services are provided on a fee-for-service basis outside of the capitation payment such as transplants, and physical, occupational and speech therapy for children if included in an Individual Education Plan or Individualized Family Service Plan. Department of Health and Senior Services testing services (tests on newborns), certain mental health services, including ICF/MR, community psychiatric rehabilitation services, CSTAR services, and mental health services for children in care and custody are also offered on a fee-for-service basis.

Improvements Over Fee-For-Service: MC+ Managed Care gives Medicaid recipients a number of advantages over traditional fee-for-service Medicaid. Each MC+ Managed Care enrollee chooses a health plan and a primary care provider from within the network of the health plan. MC+ Managed Care enrollees are guaranteed access to primary care and other services, as needed. Health plans must ensure that routine exams are scheduled within thirty days, urgent care scheduled within two days, and emergency services must be available at all times. MC+ Managed Care health plans must ensure that children receive all EPSDT exams (complete physicals on a regular schedule), are fully immunized, and receive any medically necessary services. MC+ Managed Care health plans are required to provide case management to ensure that enrollee services, especially children's and pregnant women's, are properly coordinated. The state may track service utilization and costs under the traditional Medicaid program, but the agency is not able to control costs or monitor quality of care effectively. Managed care provides the means to control costs, but more importantly provides the means to ensure access, manage and coordinate benefits, and monitor quality of care and outcomes.

Quality Assessment: The purpose of quality assessment is to assess the quality of services in the MC+ Managed Care program. Quality assessment utilizes a variety of methods and tools to measure outcomes of services provided. The goal is to monitor ① health care services provided to MC+ Managed Care members by the health plans, and ② compliance with federal, state and contract requirements. The health plans must meet program standards for quality improvement, systems, member services, provider services, record keeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the MC+ Managed Care contracts. Quality assessment measures will be taken from HEDIS (Health Plan Employer and Data Information Set) and other internally developed measurements. HEDIS is a strong public/private effort that includes a standardized set of measures to assess and encourage the continual improvement in the quality of health care. Specifically, Medicaid HEDIS includes additional quality and access measures which respond more directly to needs of women and children, who make up the majority of MC+ Managed Care enrollees. Medicaid HEDIS is intended to be used collaboratively by the agency and health plans to:

- ♦ Provide the agency with information on the performance of the contracted health plans
- ♦ Assist health plans in quality improvement efforts
- ♦ Support emerging efforts to inform Medicaid clients about managed care plan performance
- ♦ Promote standardization of health plan reporting across the public and private sectors

An annual report will be provided with significant outcomes measured, including the following:

- ♦ Member complaints and grievances and actions taken; reasons for members changing health plans
- ♦ Utilization review: inpatient/outpatient visits for both physical and mental health
- ♦ Outcome indicators (diabetes, asthma, low birth weight, mortality)
- ♦ EPSDT activities (children's health services): Number of well child visits provided
- ♦ Prenatal activities and services provided

Contract Compliance: Along with quality assessment, monitoring health plan compliance to contractual requirements is a primary method to measure whether the goals of managed care are being met. Contractual compliance monitoring begins with the issuance of the Request for Proposal (RFP) and continues throughout the contract. Contract compliance is measured through a variety of methods. The division has a relationship with the Missouri Department of Insurance to analyze health plan provider networks in accordance with 20 CSR 400-7.095 to ensure that the network is adequate to meet the needs of enrollees.

Member Satisfaction: Member satisfaction with the health plans is another method for measuring success of the MC+ Managed Care program. An initial measurement is how many members actually choose their health plan versus the Division assigning them to health plans. MC+ Managed Care has a high voluntary choice percentage. Since the inception of the MC+ managed care program, less than 10% of enrollees are randomly assigned. Reporting has been developed to continuously monitor how many recipients initially choose their health plans as well as which health plans are chosen. Other reporting that has been developed monitors recipients' transfer requests among health plans to identify health plans that have particular problems keeping their enrollees. The Division also looks at the number of calls coming into our recipient and provider hot lines to assess problem areas with health plans. Health plans submit enrollee satisfaction data to the Department of Health and Senior Services in accordance with 19 CSR 10-5.010.

Managed Care Provider Tax: The 93rd Missouri General Assembly, 2005 passed legislation establishing a Medicaid managed care organization reimbursement allowance to be paid by all Missouri Medicaid-only health benefit plans for the privilege of engaging in the business of providing health benefit services in Missouri. The tax is based on Medicaid total revenues. The tax may be withheld from each managed care organization's Medicaid check through an offset or the managed care organization may send a check or money order. The provider tax took effect on July 1, 2005.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.166; Federal law: Social Security Act Sections 1115, 1902(a)(4), 1903(m), 1915(b), 1932; Federal Regulations: 42 CFR 438

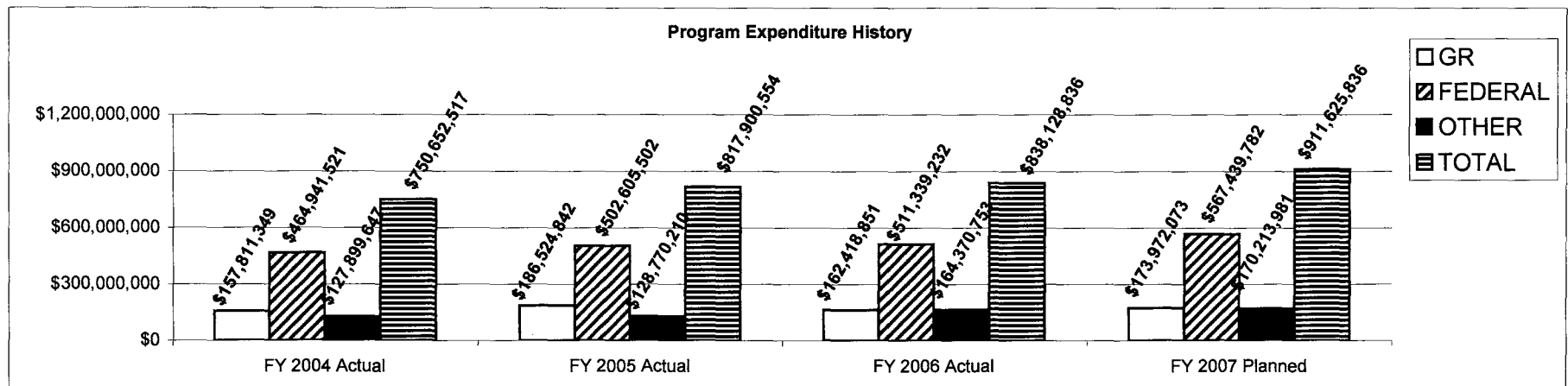
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Managed care covers most services available to fee for service eligibles. As such, both mandatory and non-mandatory services are included. Services not included in managed care are available fee for service.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

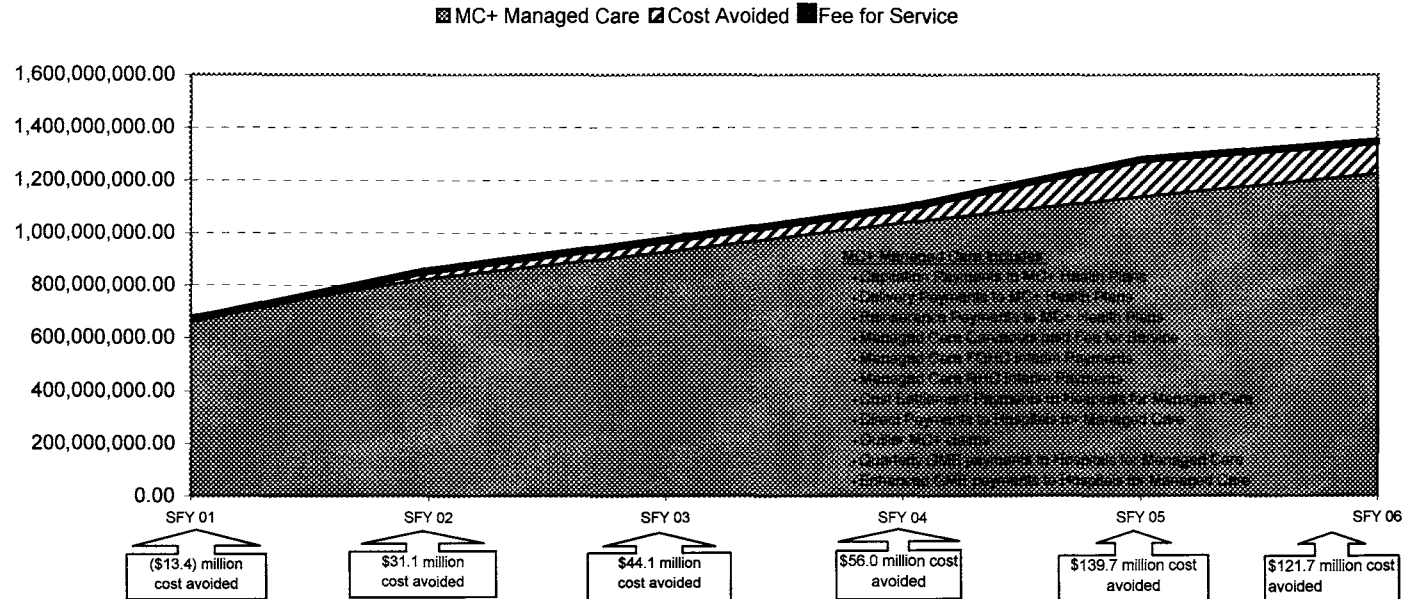
Federal Reimbursement Allowance Fund (0142), Health Initiatives Fund (0275), Healthy Families Trust Fund-Health Care Account (0640) and Medicaid Managed Care Organization Reimbursement Allowance Fund (0160) were new in FY 06. They comprise the total of the "other" fund for FY 07.

7a. Provide an effectiveness measure.

See Attachment A--"Since MC+ Managed Care Began"

7b. Provide an efficiency measure.

Cost Avoidance Attributable to MC+ Managed Care



7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Participation in MC+ managed care for those areas of the state where it is available is mandatory for these eligibility categories:

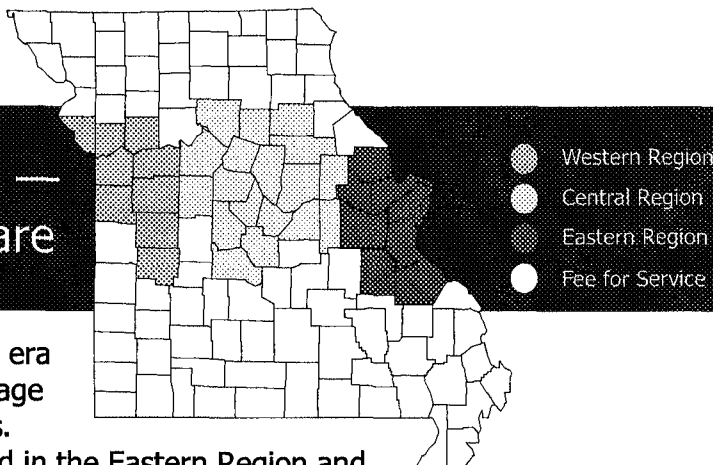
- Medical assistance for families
- MC+ for children
- Refugees
- MC+ for pregnant women
- Children in state care and custody
- 1115 waiver children

Managed Care Enrollees (Excludes 1115 Waiver Eligibles)		
SFY	Actual	Projected
2004	381,937	
2005	375,250	
2006	339,918	382,633
2007		330,035
2008		323,171
2009		316,449

7d. Provide a customer satisfaction measure, if available.

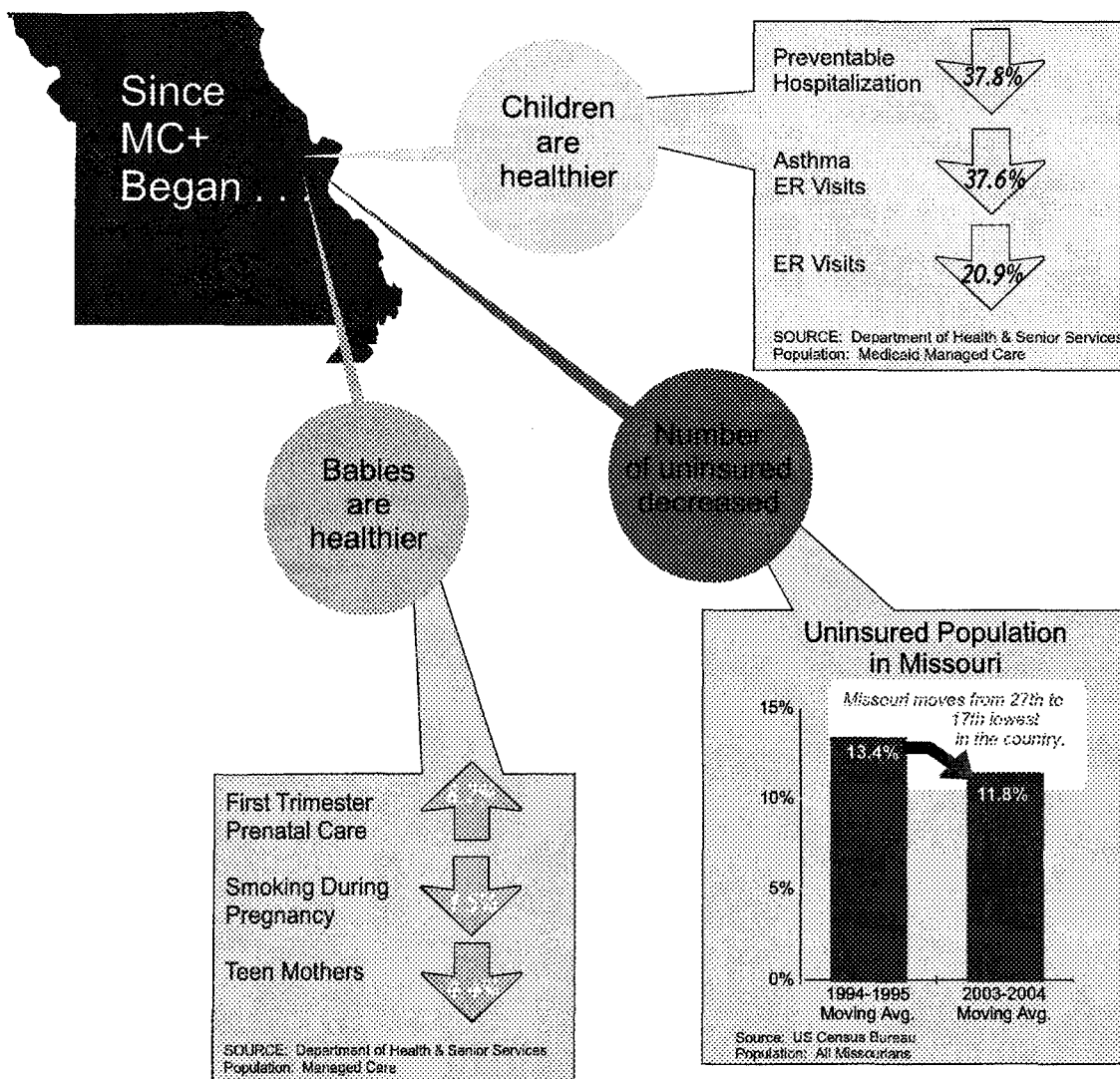
See Attachment B--"2005 Consumer's Guide MC+ Managed Care in Missouri".

Missouri Medicaid — MC+ Managed Care



In 1995 Missouri began a new era of providing health care coverage for its most vulnerable citizens.

Medicaid managed care started in the Eastern Region and now stretches through a corridor encompassing counties in central and western Missouri. Since its inception, positive results have been realized.



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For MC+ managed care participants, maternal behavior and infant indicators have improved since MC+ managed care began.

HEALTHY BABIES

Achieved Since
Start of MC+ Managed Care

Maternal & Infant Behavior Indicators

- Inadequate Prenatal Care Reduced by 8.3%
- First Trimester Prenatal Care Improved by 8.2%
- Teen Mothers Reduced by 4.4%
- Repeat Teen Births Reduced by 2.8%
- Smoking During Pregnancy Reduced by 1.5%
- Short Intervals Between Pregnancies Reduced by 1.2%
- Low Birth Weight Reduced by 0.5%

Health care indicators for children participating in MC+ managed care have also shown improvement.

HEALTHY CHILDREN

Achieved Since
Start of MC+ Managed Care

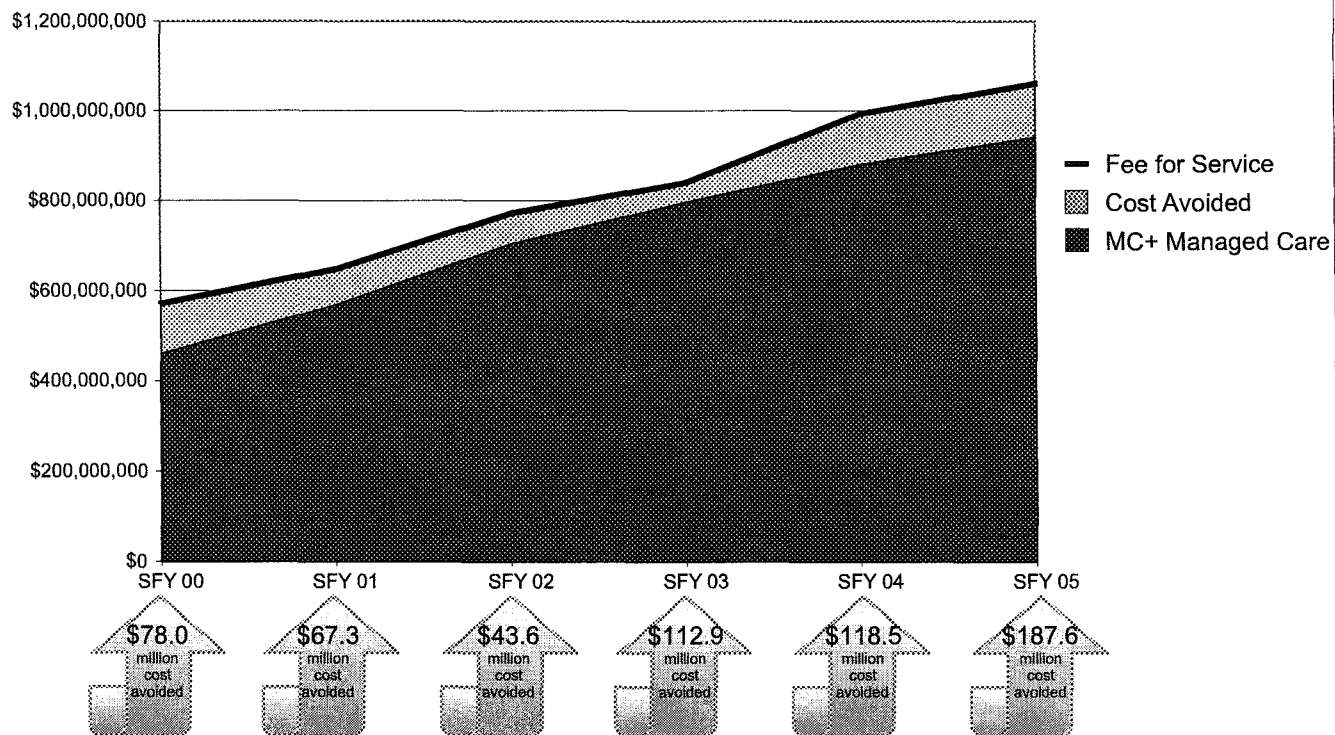
Hospital Utilization Indicators

- Asthma Admissions Under 18 Years of Age Reduced 40.3%
- Preventable Hospitalization Under 18 Years of Age Reduced 37.8%
- ER Asthma Visits Ages 4-17 Reduced 37.6%
- Emergency Room (ER) Visits Under 18 Years of Age Reduced 20.9%

Source: Department of Health & Senior Services, comparison of calendar year 2004 to baseline data (1994 or 1995 depending on region)

Because health care for these participants was provided under managed care instead of fee for service, we estimate \$187.6 million in costs were avoided in 2005.

Cost Avoidance Attributable to MC+ Managed Care



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2005 Consumer's Guide

MC+ Managed Care in Missouri



MC+ Managed Care

MC+ is the statewide medical assistance program for low-income families, pregnant women, children and uninsured parents. MC+ recipients get their care through either Fee-for-Service (FFS) or managed care depending on where the person lives in Missouri. MC+ managed care is in 37 Missouri counties. MC+ managed care members must choose a health plan and a primary care provider (PCP). A PCP directs a member's health care. The PCP will refer the member to other health care providers when needed. There are some services not in MC+ managed care that are covered by MC+ FFS.

Table of Contents

Know Your Rights	3
Know Your Responsibilities	4
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MC+ Managed Care Plan Performance —	
Women's Health	6
Children's Health	7
Member Satisfaction	8
Eligibility and Enrollment Toll Free Numbers	9

Know Your Rights

You have the right to:

- ◆ Be treated with respect and dignity
- ◆ Receive needed medical services
- ◆ Have privacy and confidentiality (including minors) subject to state and federal laws
- ◆ Select your own PCP
- ◆ Refuse care from a specific provider
- ◆ Receive information about your health care and treatment options
- ◆ Participate in decision-making about your health
- ◆ Have access to your medical records
- ◆ Have someone act on your behalf if you are unable to do so
- ◆ Receive information in a manner and format that can be easily understood
- ◆ Receive information on physician incentive plans, if any
- ◆ Be free of restraint or seclusion from a provider who wants to:
 1. Make you do something you should not
 2. Punish you
 3. Get back at you
 4. Make things easier for him or herself
- ◆ Be free to exercise these rights without retaliation

Know Your Responsibilities

Learn the rules of your MC+ managed care plan before you get medical care. You have a responsibility to:

- ◆ Pick a primary care provider (PCP)
- ◆ Make and keep appointments, or call ahead to cancel
- ◆ Ask questions about your health care, talk to your PCP or managed care plan
- ◆ Call your PCP before you get care from another provider, or you may have to pay the bill
- ◆ Use urgent care facilities for urgent health care conditions that are not emergencies
- ◆ Eat right, exercise, get regular checkups, don't smoke and follow your PCP's instructions

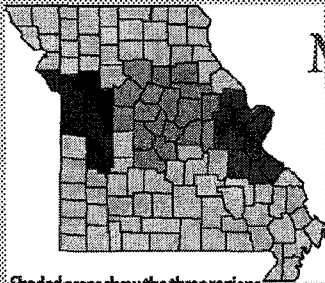
To find out about your rights, phone:
1-800-392-2161

or write: Recipient Services
Missouri Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102.

Statewide Averages and Quality of Care Symbols Explained

The percent on the "Statewide Averages" line indicate the average percent of all plans for each indicator shown in the header of the column.

The Quality of Care Ratings reflect a statistical comparison of the plan's percentage on the indicator (measure) and the statewide average percentage for all plans. An Average (●) rating for a specific plan means the plan scored close to the Statewide Average for that indicator. A High (●) or Low (○) rating means the plan scored much higher or much lower than the Statewide Average.



Shaded areas show the three regions where MC+ managed care plans offer coverage

MC+ Managed Care Plan Performance

Women's Health

Eastern Region

Community Care Plus	●	●	YES
HealthCare USA of Missouri	●	●	YES
Mercy MC+	○	○	none

Central Region

HealthCare USA of Missouri	○	●	YES
Missouri Care Health Plan	○	●	YES

Western Region

Blue-Advantage Plus	○	●	YES
Family Health Partners	●	●	YES
FirstGuard Health Plan	●	●	YES
HealthCare USA of Missouri	●	○	YES

Statewide Averages

59%

63%

This table compares health plans' performance on Women's Health Care measures to the statewide average, using the rating symbols below. The table also reports on which plans offer selected benefits and coverages.

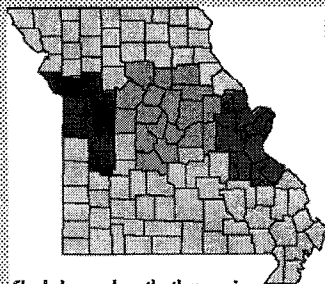
Female plan members (ages 16-20) who are sexually active and had at least one test for chlamydia (an STD) during the past year.

Women (ages 21-64) who had a pap test in the past two years.

Plan provides educational information to members who are at risk for High Risk Pregnancy.

Quality of Care Ratings*

- — High
 - — Average
 - — Low/Needs Improvement
 - NA Numbers too small
 - NR Not reported by plan
- *Plan performance measures are compared to statewide averages



Shaded areas show the three regions where MC+ managed care plans offer coverage

MC+ Managed Care Plan Performance

Children's Health

	Use of Appropriate Medication for People with Asthma	Childhood Immunizations	Adolescent Immunizations	Adolescent Well-Care Visit	Obesity Education of All Plan Enrollees	Yearly Dental Visits
Eastern Region						
Community Care Plus	○	●	●	○	Yes	●
HealthCare USA of Missouri	●	○	○	●	none	●
Mercy MC+	●	●	●	●	none	○
Central Region						
HealthCare USA of Missouri	●	○	○	●	none	○
Missouri Care Health Plan	●	●	●	●	YES	●
Western Region						
Blue-Advantage Plus	●	●	○	●	none	●
Children's Mercy's Family Health Partners	●	●	●	●	YES	●
FirstGuard Health Plan	●	●	●	●	none	○
HealthCare USA of Missouri	NA	○	●	○	none	○
Statewide Averages	67%	46%	45%	33%		28%

405

Child members (ages 5-9) who have persistent asthma and are being given acceptable medications for long term control of asthma.

Children who turned 2 in the past year and received vaccinations.

Adolescents who turned 13 in the past year and received vaccinations.

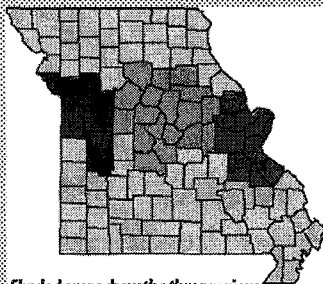
Adolescents (ages 12-21) who had a well care visit during the past year.

Plan provides educational information for members about risks of obesity.

Children and young adults (ages 4-21) who had one or more dental visits during the past year.

Quality of Care Ratings*

- — High
 - — Average
 - — Low/Needs Improvement
 - NA Numbers too small
 - NR Not reported by plan
- *Plan performance measures are compared to statewide averages



Shaded areas show the three regions where MC+ managed care plans offer coverage

MC+ Managed Care Plan Performance

Member Satisfaction

	Customer Service (1)	Getting Care Quickly (2)	Getting Needed Care (3)	Rating of Doctor Seen Most Often (4)	Rating of Specialist Seen Most Often (5)	Overall Rating of Plan (6)
Eastern Region						
Community Care Plus	●	●	●	●	○	●
HealthCare USA of Missouri	●	●	●	●	●	●
Mercy MC+	●	●	●	●	●	●
Central Region						
HealthCare USA of Missouri	○	●	●	●	●	●
Missouri Care Health Plan	●	●	●	●	●	●
Western Region						
Blue-Advantage Plus	●	●	●	●	●	●
Children's Mercy's Family Health Partners	●	●	●	●	●	●
FirstGuard Health Plan	●	●	●	●	●	●
HealthCare USA of Missouri	●	●	●	●	●	●
Statewide Averages	73%	80%	80%	81%	74%	78%

Statewide Averages and Quality of Care Symbols are explained on page 5.

Response Descriptions for Satisfaction Categories Above

- (1) No problem with paperwork, written materials or help from customer service.
- (2) No problem getting necessary care in a reasonable time.
- (3) No problem getting good doctors and nurses, referrals, and necessary care.
- (4) Overall rating of personal doctor seen most often.
- (5) Overall rating of specialist seen most often.
- (6) Overall rating of health plan.

Quality of Care Ratings*

- High
- Average
- Low/Needs Improvement
- NA Numbers too small
- NR Not reported by plan
- *Plan performance measures are compared to statewide averages

Member Services Telephone Numbers

MC+ Plan	Customer Service Nurse Helpline	
Blue Advantage Plus	816-395-2119	800-693-7153
Blue Cross Blue Shield KC		
Community Care Plus	800-875-0679	800-875-0679
Family Health Partners	800-347-9363	800-347-9363
FirstGuard Health Plan	888-828-5698	888-427-2286
HealthCare USA	800-566-6444	800-475-1142
Mercy MC+	800-796-0056	800-811-1187
Missouri Care	800-322-6027	888-884-2401

*You may contact the following State agency about
MC+ managed care plan problems.*

Division of Medical Services

1-800-392-2161

<http://dms.missouri.gov/dms/>



For further information about this Consumer's Guide, contact:
Missouri Dept. of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570
(573) 751-6272

The Missouri Department of Health and Senior Services has attempted to publish accurate information based upon common definitions. The data reported are based on plan performance during 2004. Managed care plans were given an opportunity to review and correct the data presented. Other corrections or suggestions should be forwarded to the Center for Health Information Management and Evaluation (CHIME), Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO 65102. Our telephone number is (573) 751-6272.

The Missouri Department of Health and Senior Services is an equal opportunity/affirmative action employer. Services are provided on a nondiscriminatory basis. This information is available in alternate formats to citizens with disabilities.

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	0	0.00	0	0.00	7,000,000	0.00	7,000,000	0.00
TITLE XIX-FEDERAL AND OTHER	126,975	0.00	0	0.00	7,215,000	0.00	7,215,000	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	126,975	0.00	0	0.00	215,000	0.00	215,000	0.00
HFT-HEALTH CARE ACCT	0	0.00	100,000	0.00	0	0.00	0	0.00
TOTAL - EE	253,950	0.00	100,000	0.00	14,430,000	0.00	14,430,000	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	20,288,779	0.00	36,326,369	0.00	24,473,741	0.00	24,473,741	0.00
TITLE XIX-FEDERAL AND OTHER	405,329,378	0.00	426,603,004	0.00	417,581,905	0.00	417,581,905	0.00
UNCOMPENSATED CARE FUND	32,483,522	0.00	32,483,522	0.00	32,483,522	0.00	32,483,522	0.00
THIRD PARTY LIABILITY COLLECT	1,106,786	0.00	1,062,735	0.00	1,062,735	0.00	1,062,735	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	149,615,655	0.00	150,057,328	0.00	135,467,390	0.00	135,467,390	0.00
HEALTH INITIATIVES	2,713,264	0.00	2,797,179	0.00	2,797,179	0.00	2,797,179	0.00
HEALTHY FAMILIES TRUST	0	0.00	0	0.00	42,731,431	0.00	42,731,431	0.00
HFT-HEALTH CARE ACCT	42,731,430	0.00	42,631,431	0.00	0	0.00	0	0.00
TOTAL - PD	654,268,814	0.00	691,961,568	0.00	656,597,903	0.00	656,597,903	0.00
TOTAL	654,522,764	0.00	692,061,568	0.00	671,027,903	0.00	671,027,903	0.00
Medicaid Caseload Growth - 1886033								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	1,453,713	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	2,394,124	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	3,847,837	0.00	0	0.00
TOTAL	0	0.00	0	0.00	3,847,837	0.00	0	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,755,965	0.00	3,755,965	0.00
TOTAL - PD	0	0.00	0	0.00	3,755,965	0.00	3,755,965	0.00
TOTAL	0	0.00	0	0.00	3,755,965	0.00	3,755,965	0.00

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FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
Medical for Foster Children - 1886057								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	91,217	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	150,226	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	241,443	0.00
TOTAL	0	0.00	0	0.00	0	0.00	241,443	0.00
Medical for Employed Disabled - 1886062								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	1,148,250	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	1,891,056	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	3,039,306	0.00
TOTAL	0	0.00	0	0.00	0	0.00	3,039,306	0.00
Provider Tax GR Replacement - 1886066								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	14,374,938	0.00	14,374,938	0.00
TOTAL - PD	0	0.00	0	0.00	14,374,938	0.00	14,374,938	0.00
TOTAL	0	0.00	0	0.00	14,374,938	0.00	14,374,938	0.00
GRAND TOTAL	\$654,522,764	0.00	\$692,061,568	0.00	\$693,006,643	0.00	\$692,439,555	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Hospital Care

Budget Unit: 90552C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE	7,000,000	7,215,000	215,000	14,430,000	EE	7,000,000	7,215,000	215,000	14,430,000
PSD	24,473,741	417,581,905	214,542,257	656,597,903	PSD	24,473,741	417,581,905	214,542,257	656,597,903
TRF					TRF				
Total	31,473,741	424,796,905	214,757,257	671,027,903	Total	31,473,741	424,796,905	214,757,257	671,027,903
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Uncompensated Care Fund (UCF) (0108)
Federal Reimbursement Allowance Fund (FRA) (0142)
Health Initiatives Fund (HIF) (0275)
Third Party Liability Collections Fund (TPL) (0120)
Healthy Families Trust Fund (0625)

Note: An "E" is requested for appropriation to support trauma center payments, Federal Funds and FRA Funds.

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Uncompensated Care Fund (UCF) (0108)
Federal Reimbursement Allowance Fund (FRA) (0142)
Health Initiatives Fund (HIF) (0275)
Third Party Liability Collections Fund (TPL) (0120)
Healthy Families Trust Fund (0625)

Note: An "E" is requested for appropriation to support trauma center payments, Federal Funds and FRA Funds.

2. CORE DESCRIPTION

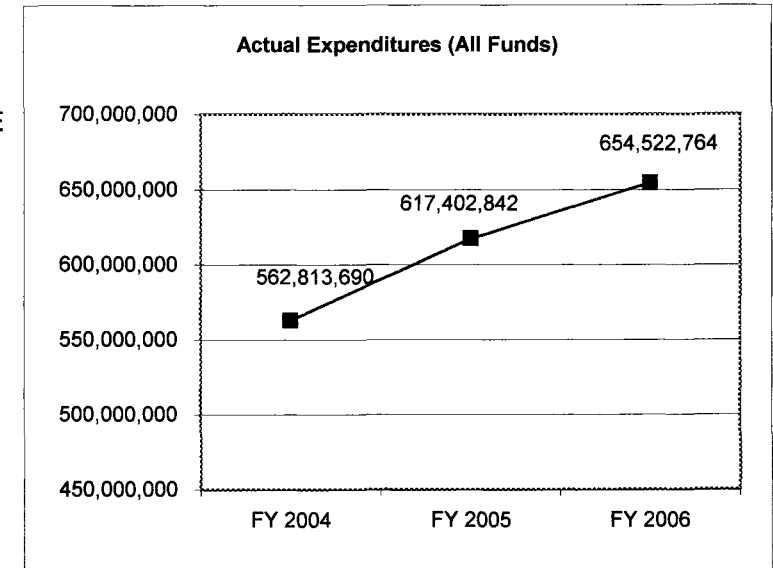
This core request is for ongoing funding to reimburse hospitals for services provided to fee-for-service Title XIX Medicaid clients. Funding for this core is used to maintain hospital reimbursement at a sufficient level to ensure quality health care and provider participation.

3. PROGRAM LISTING (list programs included in this core funding)

Hospital Care

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	613,112,605	667,838,537	654,998,700	692,061,568 E
Less Reverted (All Funds)	(83,915)	(83,915)	(83,915)	N/A
Budget Authority (All Funds)	613,028,690	667,754,622	654,914,785	N/A
Actual Expenditures (All Funds)	562,813,690	617,402,842	654,522,764	N/A
Unexpended (All Funds)	50,215,000	50,351,780	392,021	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	30,115,000	30,175,890	142,322	N/A
Other	20,100,000	20,175,890	249,699	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriation for trauma center Federal Fund and FRA Fund for FY 2004 thru FY 2007.

(1) Agency reserve of \$50,000,000 for trauma center payments. State Plan Amendment to make trauma payments not approved. Expenditures of \$10,737,113 were paid from the Supplemental Pool.

(2) State Plan Amendment to make trauma payments (\$50,000,000) still not approved. Expenditures of \$24,843,767 were paid from the Supplemental Pool.

(3) Expenditures of \$46,150,882 were paid from the Supplemental Pool and expenditures totaling \$6,309,518 were paid from the Managed Care appropriation. "E" increase hospital trauma FF by \$1,950,000.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
HOSPITAL CARE

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			EE	0.00	0	0	100,000	100,000	
			PD	0.00	36,326,369	426,603,004	229,032,195	691,961,568	
			Total	0.00	36,326,369	426,603,004	229,132,195	692,061,568	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1668 1432	PD		0.00	(1,096,663)	0	0	(1,096,663)	Core Cut -- MAWD
Core Reduction	1668 6471	PD		0.00	0	(1,806,099)	0	(1,806,099)	Core Cut -- MAWD
Core Reduction	1711 1432	PD		0.00	(3,755,965)	0	0	(3,755,965)	FMAP Adjustment
Core Reduction	3246 0776	PD		0.00	0	0	(14,374,938)	(14,374,938)	Core Cut - Provider Tax Cap Reduction
Core Reallocation	1178 1432	EE		0.00	7,000,000	0	0	7,000,000	
Core Reallocation	1178 6744	EE		0.00	0	0	215,000	215,000	
Core Reallocation	1178 6471	EE		0.00	0	7,000,000	0	7,000,000	
Core Reallocation	1178 5515	EE		0.00	0	0	(100,000)	(100,000)	
Core Reallocation	1178 6745	EE		0.00	0	215,000	0	215,000	
Core Reallocation	1178 5515	PD		0.00	0	0	100,000	100,000	
Core Reallocation	1178 1432	PD		0.00	(7,000,000)	0	0	(7,000,000)	
Core Reallocation	1178 6745	PD		0.00	0	(215,000)	0	(215,000)	
Core Reallocation	1178 6744	PD		0.00	0	0	(215,000)	(215,000)	
Core Reallocation	1178 6471	PD		0.00	0	(7,000,000)	0	(7,000,000)	
Core Reallocation	2112 4079	PD		0.00	0	0	(30,365,444)	(30,365,444)	Reallocation of #0640 to #0625
Core Reallocation	2112 3714	PD		0.00	0	0	30,365,444	30,365,444	Reallocation of #0640 to #0625

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
HOSPITAL CARE

5. CORE RECONCILIATION DETAIL

		Budget Class	FTE	GR	Federal	Other	Total	Explanation
DEPARTMENT CORE ADJUSTMENTS								
Core Reallocation	2118 5517	PD	0.00	0	0	(10,000,000)	(10,000,000)	Reallocation from #0640 to #0625
Core Reallocation	2118 3713	PD	0.00	0	0	10,000,000	10,000,000	Reallocation from #0640 to #0625
Core Reallocation	2119 5515	PD	0.00	0	0	(2,365,987)	(2,365,987)	Reallocation from #0640 to #0625
Core Reallocation	2119 3712	PD	0.00	0	0	2,365,987	2,365,987	Reallocation from #0640 to #0625
NET DEPARTMENT CHANGES			0.00	(4,852,628)	(1,806,099)	(14,374,938)	(21,033,665)	
DEPARTMENT CORE REQUEST								
		EE	0.00	7,000,000	7,215,000	215,000	14,430,000	
		PD	0.00	24,473,741	417,581,905	214,542,257	656,597,903	
		Total	0.00	31,473,741	424,796,905	214,757,257	671,027,903	
GOVERNOR'S RECOMMENDED CORE								
		EE	0.00	7,000,000	7,215,000	215,000	14,430,000	
		PD	0.00	24,473,741	417,581,905	214,542,257	656,597,903	
		Total	0.00	31,473,741	424,796,905	214,757,257	671,027,903	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HOSPITAL CARE								
CORE								
PROFESSIONAL SERVICES	253,950	0.00	100,000	0.00	14,430,000	0.00	14,430,000	0.00
TOTAL - EE	253,950	0.00	100,000	0.00	14,430,000	0.00	14,430,000	0.00
PROGRAM DISTRIBUTIONS	654,268,814	0.00	691,961,568	0.00	656,597,903	0.00	656,597,903	0.00
TOTAL - PD	654,268,814	0.00	691,961,568	0.00	656,597,903	0.00	656,597,903	0.00
GRAND TOTAL	\$654,522,764	0.00	\$692,061,568	0.00	\$671,027,903	0.00	\$671,027,903	0.00
GENERAL REVENUE	\$20,288,779	0.00	\$36,326,369	0.00	\$31,473,741	0.00	\$31,473,741	0.00
FEDERAL FUNDS	\$405,456,353	0.00	\$426,603,004	0.00	\$424,796,905	0.00	\$424,796,905	0.00
OTHER FUNDS	\$228,777,632	0.00	\$229,132,195	0.00	\$214,757,257	0.00	\$214,757,257	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Hospital Care

Program is found in the following core budget(s): Hospital Care

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for inpatient and outpatient hospital services for fee for service Medicaid/MC+ recipients.

Hospital services, inpatient and outpatient, are an essential part of a health care delivery system. These services are mandatory Medicaid-covered services and are provided statewide. Hospital services have been part of the Missouri Medicaid program since November 1967. Medicaid inpatient hospital services are medical services provided in a hospital acute care setting for the care and treatment of Medicaid recipients.

Medicaid outpatient hospital services include preventative, diagnostic, emergency, therapeutic, rehabilitative or palliative services provided in an outpatient setting. Examples of outpatient services are emergency room services, physical therapy, ambulatory surgery, or any service/procedure done prior to admission.

Providers

To participate in the Medicaid fee-for-service program, hospitals must first meet certain requirements. Hospitals must be licensed and certified by the Missouri Department of Health for participation in the Title XVIII Medicare program. If the hospital is located out of state, the hospital must be licensed by that state's Department of Health or similar agency. If a state does not have a licensing agency, the hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO). In addition, the hospital must complete a Title XIX Medicaid Participation Agreement/Questionnaire, and a Missouri Medicaid Enrollment application. The application of enrollment must be approved by the Department of Social Services/Division of Medical Services (DMS).

Medicaid Reimbursement

Reimbursement for inpatient hospital stays is determined by a prospective reimbursement plan implemented in FY 82. The plan provides for an inpatient hospital reimbursement rate based on the 1995 cost report to reimburse for inpatient stays in accordance with a specified admission diagnosis. For reimbursement purposes hospitals are divided into two groups: safety net hospitals and Disproportionate Share Hospitals (first tier and other DSH). The DSH classification is made as a result of an analysis of annual hospital cost reports.

A hospital can qualify as a Safety Net hospital if:

- it has an unsponsored care (charity care) ratio of 65%; OR
- is operated by the Board of Curators as defined in chapter 172 RSMo; OR
- is operated by the Department of Mental Health;

AND if it meets one of the following DSH criteria:

- Medicaid inpatient utilization percentage must be at least one standard deviation above the state's mean Medicaid utilization;
- Utilization of services by low-income clients must be greater than 25% of their total utilization;
- The hospital must be ranked in the top fifteen hospitals based on Medicaid patient days and their Medicaid nursery and neonatal utilization must be greater than 35% of the hospital's total nursery and neonatal utilization;
- At least 9% of their Medicaid days are provided in the hospital's neonatal unit.
- Unsponsored care ratio of at least ten percent (10%).

Once a per diem reimbursement rate is established for each hospital, it is paid for the lesser of: 1) the number of days assigned by the medical review agent; 2) the number of days billed as covered services; or 3) the Professional Activity Study (PAS) limitation for any diagnosis not subject to review by the medical review agent.

A hospital is eligible for a special per diem rate increase if it meets prescribed requirements concerning new health services or new construction.

Outpatient services, excluding certain diagnostic laboratory procedures, are paid on a prospective outpatient reimbursement methodology. The prospective outpatient payment percentage is calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth and sixth prior base year cost reports regressed to the current state fiscal year. The prospective outpatient payment percentage cannot exceed 100% and cannot be less than 20%. New Medicaid providers that do not have fourth, fifth and sixth prior year cost reports will be set at 75% for the first three fiscal years in which the hospital operates and will have a cost settlement calculated for these years. A prospective outpatient rate will then be calculated and used for the fourth and subsequent years of operation. The weighted average prospective outpatient rate is 35%.

Other Reimbursement to Hospitals

Hospitals may also receive funding from the Federal Reimbursement Allowance (FRA) program. The FRA program is a funding source for inpatient and outpatient services. It is also a funding source for MC+ Managed Care, the 1115 Waiver-Adults, and the 1115 Waiver-Children (CHIPs). These programs provide payments for the cost of providing care to Medicaid recipients and the uninsured.

Under the FRA program, hospitals pay a federal reimbursement allowance for doing business in the state. For FY07, the assessment is 5.83% of total operating revenue less tax revenue/other government appropriations, plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The financial data is required to be submitted by the hospitals to the Missouri Department of Health and Senior Services. If the pertinent information is not available through the DHSS hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report. The Division of Medical Services uses funds generated from the FRA program as the equivalent of General Revenue funds. The funds are distributed to the hospitals through a combination of payments.

The payments include funding for: inpatient per diems, outpatient payments, and add-on payments (such as direct Medicaid payments, uninsured, and utilization add-on payments). For a more detailed description of the FRA program see the FRA narrative.

Trends

The elderly and persons with disabilities are the highest users of health care services and costliest population per capita. These two populations represent 25% of all Medicaid eligibles and represent over 66% of all expenditures. Persons with disabilities are the primary users of hospital services. This group accounts for over 41% of fee-for-service hospital users and 54% of fee-for-service hospital expenditures. The elderly are 14% of fee-for-service hospital users and use over 6% of fee-for-service hospital expenditures.

One method used to control costs is the pre-certification of inpatient hospital stays and certificate of need for patients under 21 admitted to psychiatric units or facilities. The reviews are done by a medical review agent. Admission and continued stay reviews are performed on a preapproved basis for all fee for service Medicaid recipients admitted to acute care hospitals except for certain pregnancy, delivery and newborn diagnoses and Medicare/Medicaid eligibles. The reviews are done to ensure that hospital admission and each day of inpatient care are medically necessary. The review may be performed prior to admission, post admission or retrospectively. An initial length of stay (LOS) is assigned by a nurse or physician reviewer.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2), 1923(a)-(f);
Federal Regulations: 42 CFR 440.10 and 440.20

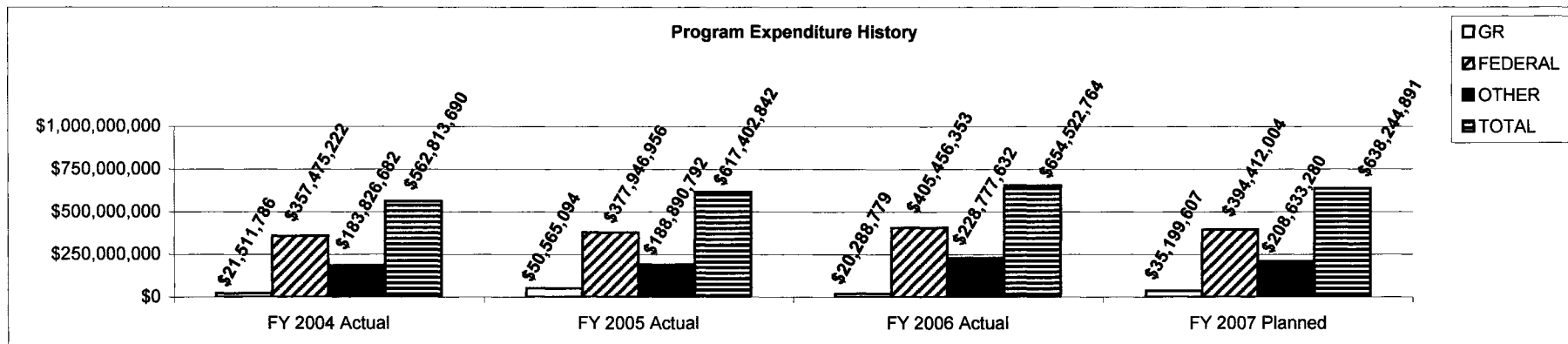
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

Yes, if the state elects to have a Medicaid program.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

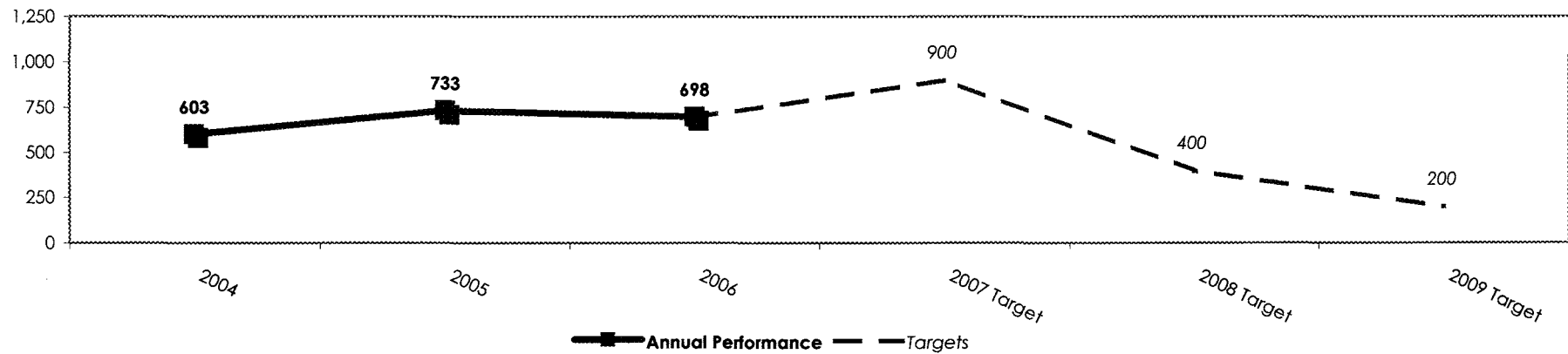


6. What are the sources of the "Other" funds?

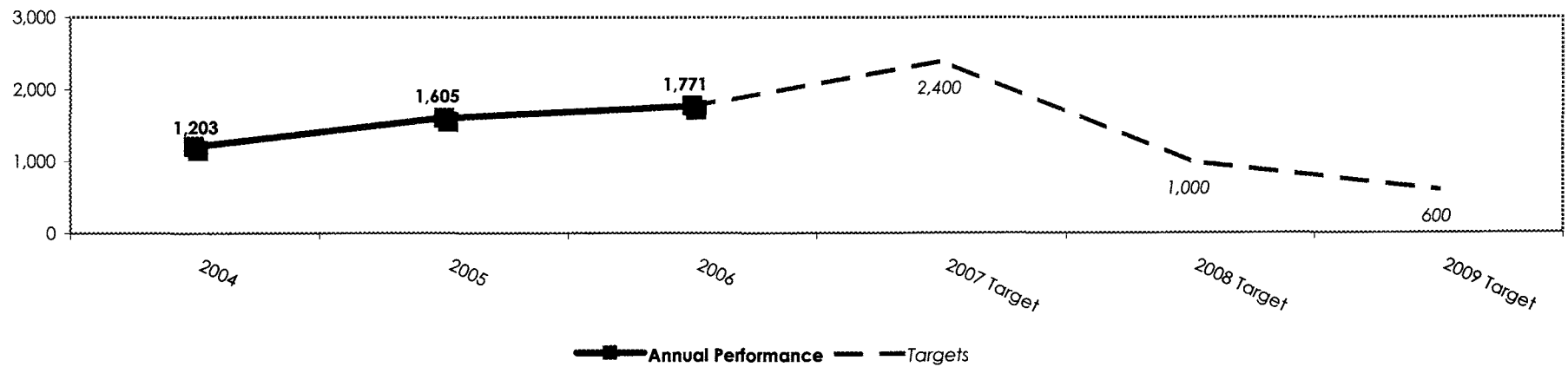
Uncompensated Care Fund (0108), Federal Reimbursement Allowance Fund (0142), Health Initiatives Fund (0275), Healthy Families Trust-Health Care Account (0640), Third Party Liability Collections Fund (0120) and Intergovernmental Transfer Fund (0139) in FY04 and FY05.

7a. Provide an effectiveness measure.

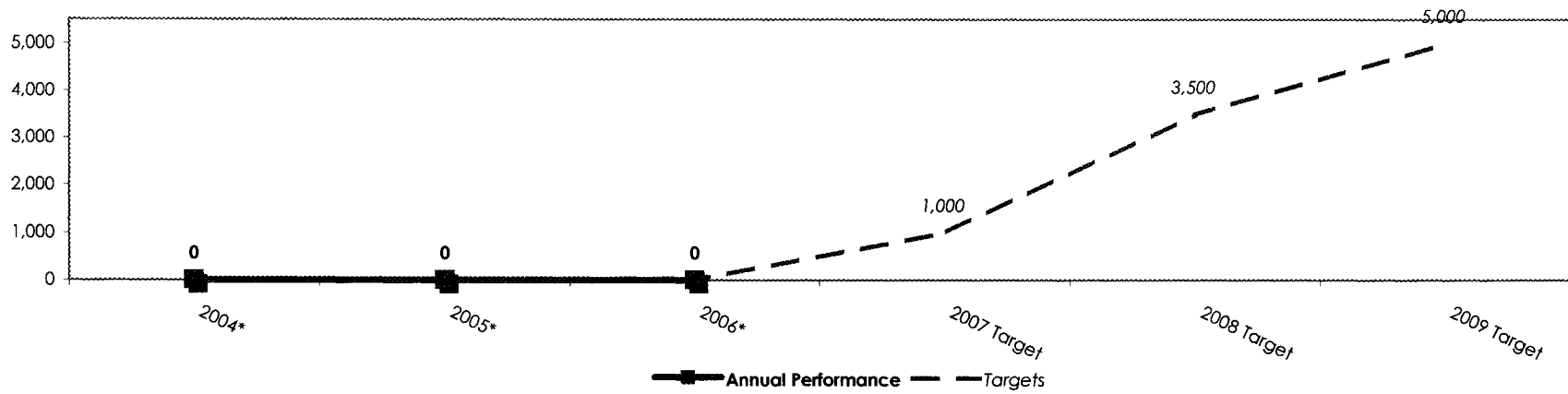
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

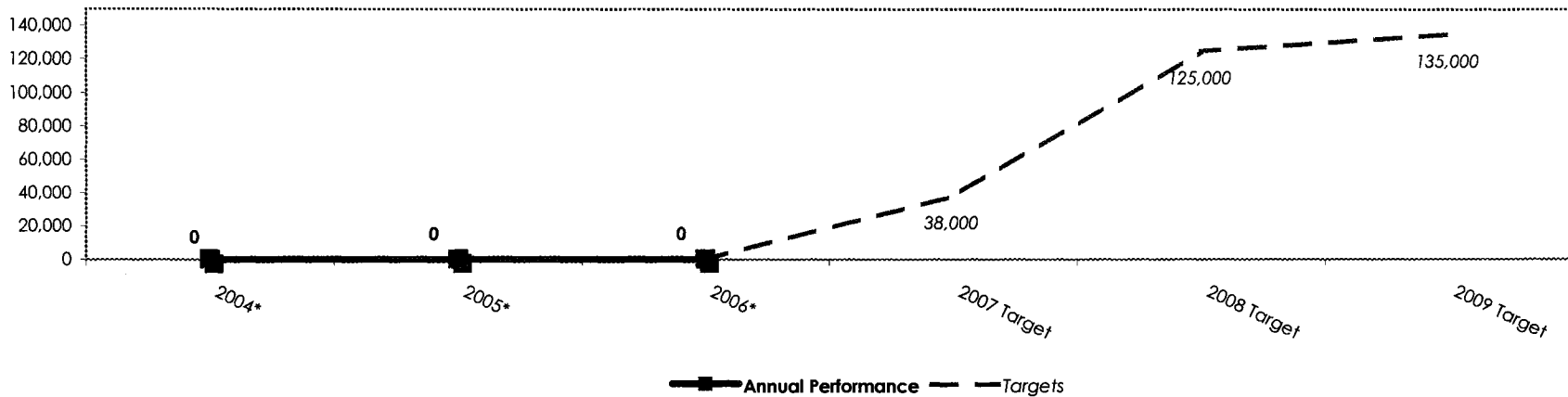


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Inpatient and outpatient services are available to all fee for service Medicaid/MC+ eligibles. In those regions of the state where MC+ managed care has been implemented enrollees have hospital services available through the MC+ managed care health plans.

Average Monthly Hospital Services Users		
SFY	Actual	Projected
2004	100,604	
2005	102,883	
2006	101,917	104,941
2007		105,387
2008		108,975
2009		112,686

Number of Inpatient Days (Thousands)		
SFY	Actual	Projected
2004	585.8	606.8
2005	640.9	612.9
2006	458.4	698.6
2007		474.2
2008		490.7
2009		507.6

Number of Outpatient Services (Thousands)		
SFY	Actual	Projected
2004	5,887.0	5,168.0
2005	6,943.2	7,064.0
2006	8,162.6	8,193.0
2007		9,662.1
2008		11,437.0
2009		13,538.0

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
TIER 1 SAFETY NET HOSPITALS								
CORE								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	5,123,586	0.00	23,000,000	0.00	23,000,000	0.00	23,000,000	0.00
TOTAL - PD	5,123,586	0.00	23,000,000	0.00	23,000,000	0.00	23,000,000	0.00
TOTAL	5,123,586	0.00	23,000,000	0.00	23,000,000	0.00	23,000,000	0.00
GRAND TOTAL	\$5,123,586	0.00	\$23,000,000	0.00	\$23,000,000	0.00	\$23,000,000	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Tier 1 Safety Net Hospitals

Budget Unit: 90558C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD		23,000,000		23,000,000
TRF				
Total		23,000,000		23,000,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD		23,000,000		23,000,000
TRF				
Total		23,000,000		23,000,000
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

2. CORE DESCRIPTION

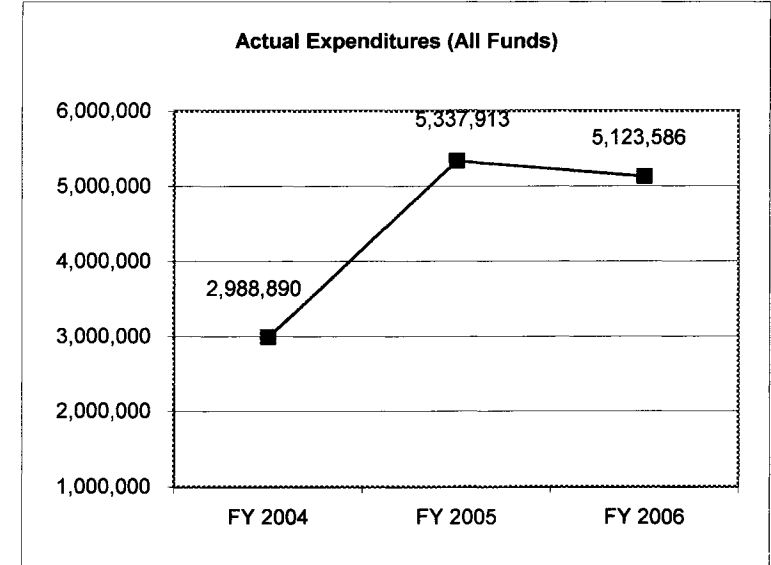
This core request is for ongoing funding to reimburse for physician services provided to Medicaid clients and the uninsured through Tier 1 Safety Net Hospitals. The payments maximize eligible costs by utilizing current state and local funding sources as match for services that are not currently matched with federal Medicaid payments.

3. PROGRAM LISTING (list programs included in this core funding)

Tier 1 Safety Net Hospitals

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	23,000,000	23,000,000	23,000,000	23,000,000
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	23,000,000	23,000,000	23,000,000	N/A
Actual Expenditures (All Funds)	2,988,890	5,337,913	5,123,586	N/A
Unexpended (All Funds)	20,011,110	17,662,087	17,876,414	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	20,011,110	17,662,087	17,876,414	N/A
Other	0	0	0	N/A
	(1) (2)	(3)	(4)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

- (1) New Program in FY 2004.
- (2) Lapse of \$20,011,110 is excess federal authority resulting from delayed implementation.
- (3) Lapse of \$17,662,087 in excess federal authority.
- (4) Lapse of \$17,876,414 in excess federal authority.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**TIER 1 SAFETY NET HOSPITALS**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	PD	0.00	0	23,000,000	0	23,000,000	
	Total	0.00	0	23,000,000	0	23,000,000	
DEPARTMENT CORE REQUEST							
	PD	0.00	0	23,000,000	0	23,000,000	
	Total	0.00	0	23,000,000	0	23,000,000	
GOVERNOR'S RECOMMENDED CORE							
	PD	0.00	0	23,000,000	0	23,000,000	
	Total	0.00	0	23,000,000	0	23,000,000	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
TIER 1 SAFETY NET HOSPITALS								
CORE								
PROGRAM DISTRIBUTIONS	5,123,586	0.00	23,000,000	0.00	23,000,000	0.00	23,000,000	0.00
TOTAL - PD	5,123,586	0.00	23,000,000	0.00	23,000,000	0.00	23,000,000	0.00
GRAND TOTAL	\$5,123,586	0.00	\$23,000,000	0.00	\$23,000,000	0.00	\$23,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$5,123,586	0.00	\$23,000,000	0.00	\$23,000,000	0.00	\$23,000,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Tier 1 Safety Net Hospitals

Program is found in the following core budget(s): Tier 1 Safety Net Hospitals

1. What does this program do?

PROGRAM SYNOPSIS: Provides payments for Medicaid clients and the uninsured through Tier 1 safety net hospitals. Safety net hospitals traditionally see a high volume of Medicaid/uninsured patients. This program was established to provide a funding mechanism to enhance payments to these hospitals.

Enhanced payments have been made to Truman Physicians and University Physicians. Appropriated funding was based on the following ideas and projections:

Enhanced Payment for Truman Physicians \$ 5,000,000

Enhanced Payment for University Physicians \$ 3,000,000

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2), 1923(a)-(f);

Federal Regulations: 42 CFR 440.10 and 440.20

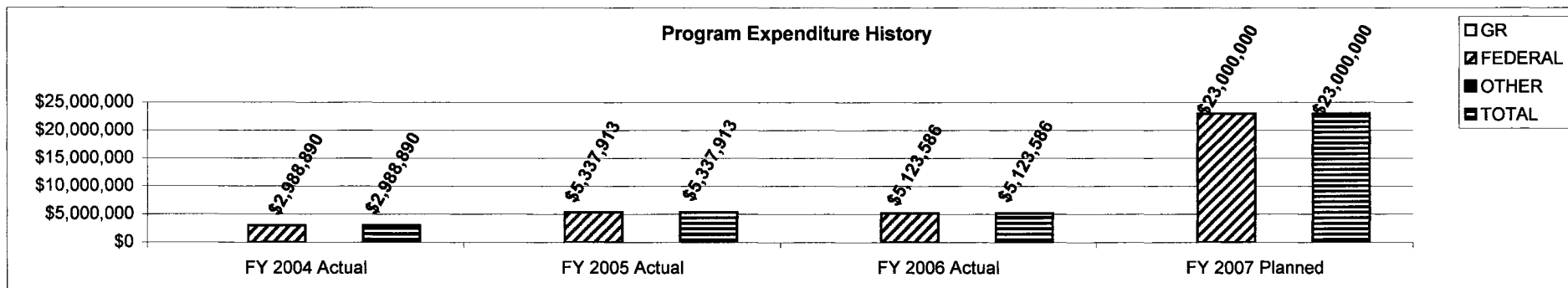
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%. For those public entities identified above who use state and local general revenue to provide eligible services to Medicaid eligible individuals, DMS provides payment of the federal share for these eligible services.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FQHC DISTRIBUTION								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	7,760,000	0.00	9,000,000	0.00	9,000,000	0.00	9,000,000	0.00
TOTAL - PD	7,760,000	0.00	9,000,000	0.00	9,000,000	0.00	9,000,000	0.00
TOTAL	7,760,000	0.00	9,000,000	0.00	9,000,000	0.00	9,000,000	0.00
FQHC Health Info Technology - 1886065								
PROGRAM-SPECIFIC								
HEALTHCARE TECHNOLOGY FUND	0	0.00	0	0.00	0	0.00	5,000,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	5,000,000	0.00
TOTAL	0	0.00	0	0.00	0	0.00	5,000,000	0.00
GRAND TOTAL	\$7,760,000	0.00	\$9,000,000	0.00	\$9,000,000	0.00	\$14,000,000	0.00

CORE DECISION ITEM

Department: Social Services
 Division: Medical Services
 Appropriation: Federally Qualified Heath Centers (FQHC) Distribution

Budget Unit: 90559C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	9,000,000			9,000,000
TRF				
Total	9,000,000			9,000,000
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD	9,000,000			9,000,000
TRF				
Total	9,000,000			9,000,000
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

2. CORE DESCRIPTION

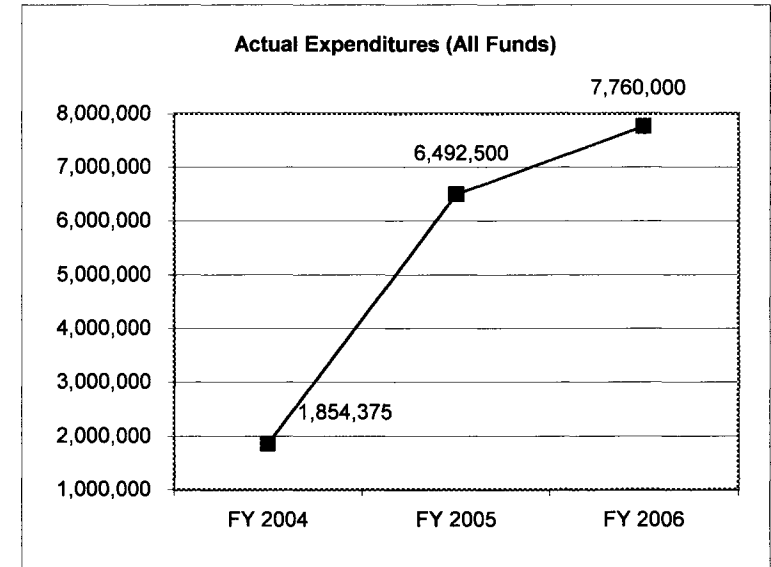
This core request is to allow Federally Qualified Health Centers (FQHCs) to provide more services in their facilities and improve access to health care for the uninsured and under-insured. Funding for this core is for equipment and infrastructure in the FQHC and to cover the expense of providing health care services in the FQHC setting.

3. PROGRAM LISTING (list programs included in this core funding)

Federally Qualified Health Centers (FQHC)

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	2,000,000	7,000,000	8,000,000	9,000,000
Less Reverted (All Funds)	(60,000)	(210,000)	(240,000)	N/A
Budget Authority (All Funds)	1,940,000	6,790,000	7,760,000	N/A
Actual Expenditures (All Funds)	1,854,375	6,492,500	7,760,000	N/A
Unexpended (All Funds)	85,625	297,500	0	N/A
Unexpended, by Fund:				
General Revenue	85,625	297,500	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**FQHC DISTRIBUTION**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES	PD	0.00	9,000,000	0	0	9,000,000	
	Total	0.00	9,000,000	0	0	9,000,000	
DEPARTMENT CORE REQUEST	PD	0.00	9,000,000	0	0	9,000,000	
	Total	0.00	9,000,000	0	0	9,000,000	
GOVERNOR'S RECOMMENDED CORE	PD	0.00	9,000,000	0	0	9,000,000	
	Total	0.00	9,000,000	0	0	9,000,000	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FHHC DISTRIBUTION								
CORE								
PROGRAM DISTRIBUTIONS	7,760,000	0.00	9,000,000	0.00	9,000,000	0.00	9,000,000	0.00
TOTAL - PD	7,760,000	0.00	9,000,000	0.00	9,000,000	0.00	9,000,000	0.00
GRAND TOTAL	\$7,760,000	0.00	\$9,000,000	0.00	\$9,000,000	0.00	\$9,000,000	0.00
GENERAL REVENUE	\$7,760,000	0.00	\$9,000,000	0.00	\$9,000,000	0.00	\$9,000,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Federally Qualified Health Centers (FQHC) Distribution

Program is found in the following core budget(s): Federally Qualified Health Centers (FQHC) Distribution

1. What does this program do?

PROGRAM SYNOPSIS: Allows Federally Qualified Health Centers to provide more services in their facilities and improve access to health care for the uninsured and under-insured. Grant funds are used for capital expansion, infrastructure redesigning, and primary health care for the uninsured.

FQHCs are community health centers that provide comprehensive primary care to low-income and medically under-served urban and rural communities. Because of an inadequate number of providers, Missourians have found it difficult to find health care providers and are subject to lengthy postponements in receiving health care services. In rural areas, these issues are more pronounced as people must frequently travel to larger cities in order to receive necessary care. By equipping the FQHCs with infrastructure and personnel, the under-served population will have increased access to health care, especially in medically under-served areas.

Examples of ways these grants help expand access to health care services for the low-income and uninsured include: 1) Supporting nontraditional hours of operation (weekend and special evening hours). FQHCs recognize that many Missourians do not have the luxury of accessing care during normal business hours. 2) Defraying the costs of caring for the uninsured. FQHCs are required to accept uninsured patient as they do insured patients. 3) Fund staff and infrastructure to provide services not usually accessible to FQHC patients such as dental services.

The Department of Social Services has contracted with the Missouri Primary Care Association to act as a fiscal intermediary for the distribution of the FQHC grants, assuring accurate and timely payments to the subcontractors and to act as a central data collection point for evaluation of program impact and outcomes. The Missouri Primary Care Association is recognized as Missouri's single primary care association by the Federal Health Resource Service Administration. The goals of the nation's Primary Care Associations are to partner in the development, maintenance and improvement of access to health care services, reducing disparities in health status between majority and minority populations.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.153, 208.201, 660.026; Federal law: Social Security Act Section 1905(a)(2); Federal regulation: 42 CFR 440.210, 440.500

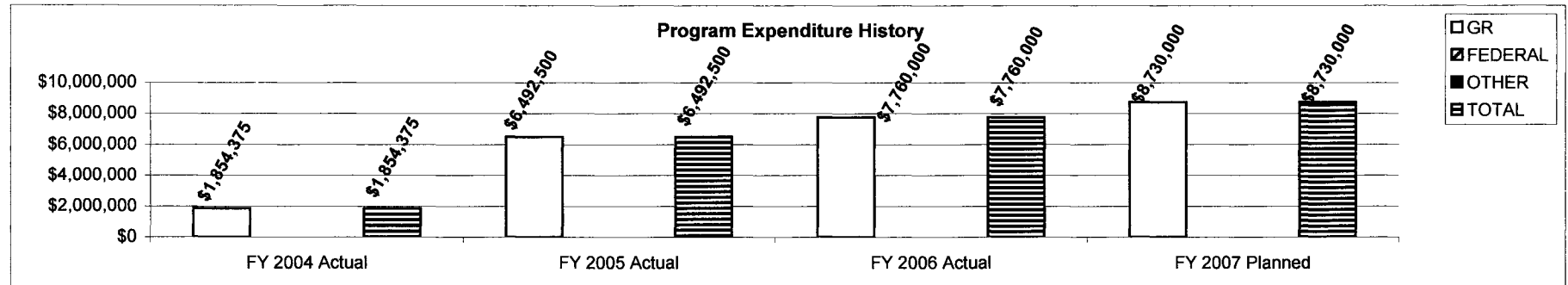
3. Are there federal matching requirements? If yes, please explain.

This is a state-only program using 100% General Revenue funding.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

These are grants to FQHC sites.

	FQHC Users by Service					
	Medical		Dental		Mental Health	
	Actual	Projected	Actual	Projected	Actual	Projected
2004	222,351	227,128	66,380	48,781	11,007	6,385
2005	242,316	229,022	71,510	76,337	12,043	13,318
2006		255,855		84,349		15,547
2007		270,150		99,493		20,070
2008		270,150		99,493		20,070
2009		270,150		99,493		20,070

Note: Information is based on calendar year.

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: FQHC Health Information Technology

Budget Unit:

DI#: 1886065

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD			5,000,000	5,000,000
TRF				
Total			5,000,000	5,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Healthcare Technology Fund (0170)

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

Funding is being requested to provide a dedicated source for Health Information Technology installation at federally qualified health centers statewide. Appropriating this funding will provide parity among safety net providers and other providers, will enhance health centers' ability to further increase health access and improve health outcomes, and will support the expansion of electronic medical records (EMRs).

State statute: RSMo. 208.153, 208.201, 660.026; Federal law: Social Security Act Section 1905(a)(2); Federal regulation: 42 CFR 440.210, 440.500

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

Federally Qualified Health Centers (FQHCs) provide access to health care for the uninsured and under-insured Missourians. Funding this decision item provides for installation of health information equipment and support of telehealth processes in health centers throughout Missouri.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions					5,000,000		5,000,000		
Total PSD	0		0		5,000,000		5,000,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	5,000,000	0.0	5,000,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

FQHC Users by Service						
	Medical		Dental		Mental Health	
	Actual	Projected	Actual	Projected	Actual	Projected
2003	215,101	216,312	49,160	46,458	7,050	6,081
2004	222,351	227,128	66,380	48,781	11,007	6,385
2005	242,316	229,022	71,510	76,337	12,043	13,318
2006		255,855		84,349		15,547
2007		270,150		99,493		20,070
2008		270,150		99,493		20,070
2009		270,150		99,493		20,070

Note: Information is based on calendar year.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

- Provide increased access to health care.
- Provide opportunities to improve health outcomes.
- Provide support for expansion of technology among FQHC's.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FQHC DISTRIBUTION								
FQHC Health Info Technology - 1886065								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	5,000,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	5,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$5,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$5,000,000	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FED REIMB ALLOWANCE								
CORE								
PROGRAM-SPECIFIC								
FEDERAL REIMBURSEMENT ALLOWANCE	688,604,798	0.00	385,000,000	0.00	385,000,000	0.00	385,000,000	0.00
TOTAL - PD	688,604,798	0.00	385,000,000	0.00	385,000,000	0.00	385,000,000	0.00
TOTAL	688,604,798	0.00	385,000,000	0.00	385,000,000	0.00	385,000,000	0.00
Adjust to Actual Activity - 1886041								
PROGRAM-SPECIFIC								
FEDERAL REIMBURSEMENT ALLOWANCE	0	0.00	0	0.00	367,000,000	0.00	367,000,000	0.00
TOTAL - PD	0	0.00	0	0.00	367,000,000	0.00	367,000,000	0.00
TOTAL	0	0.00	0	0.00	367,000,000	0.00	367,000,000	0.00
GRAND TOTAL	\$688,604,798	0.00	\$385,000,000	0.00	\$752,000,000	0.00	\$752,000,000	0.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Federal Reimbursement Allowance (FRA)

Budget Unit: 90553C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			385,000,000	385,000,000 E
TRF				
Total			385,000,000	385,000,000 E
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

Notes: An "E" is requested for the \$385,000,000 Federal Reimbursement Allowance Fund

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD			385,000,000	385,000,000 E
TRF				
Total			385,000,000	385,000,000 E
FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

Notes: An "E" is requested for the \$385,000,000 Federal Reimbursement Allowance Fund

2. CORE DESCRIPTION

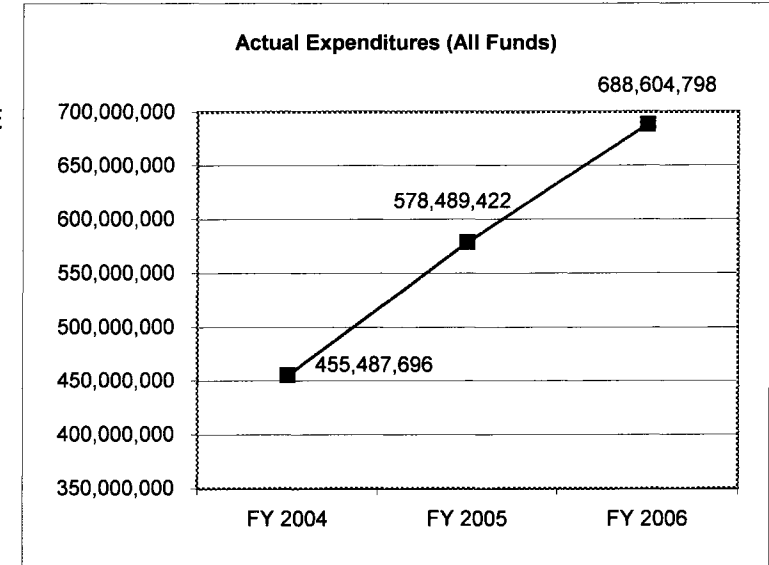
This core request is for ongoing funding to reimburse for hospital services and managed care premiums provided to Medicaid clients and the uninsured. Funding for this core is used to maintain hospital reimbursement at a sufficient level to ensure quality health care and provider participation. Hospitals are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent and when used to make valid Medicaid payments, earns federal dollars. These earnings fund this FRA program appropriation.

3. PROGRAM LISTING (list programs included in this core funding)

Hospital - Federal Reimbursement Allowance

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	455,487,700	602,283,000	689,613,669	385,000,000 E
Less Reverted (All Funds)	0	0		N/A
Budget Authority (All Funds)	455,487,700	602,283,000	689,613,669	N/A
Actual Expenditures (All Funds)	455,487,696	578,489,422	688,604,798	N/A
Unexpended (All Funds)	4	23,793,578	1,008,871	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	4	23,793,578	1,008,871	N/A
		(1)		
		(2)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriation for Federal Reimbursement Allowance Fund for FY 2004 thru FY 2007.

(1) Lapse of \$23,793,578 is excess FRA authority. Estimated appropriations were increased inappropriately.

(2) Includes 175% DSH payments.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**FED REIMB ALLOWANCE**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	PD	0.00	0	0	385,000,000	385,000,000	
	Total	0.00	0	0	385,000,000	385,000,000	
DEPARTMENT CORE REQUEST							
	PD	0.00	0	0	385,000,000	385,000,000	
	Total	0.00	0	0	385,000,000	385,000,000	
GOVERNOR'S RECOMMENDED CORE							
	PD	0.00	0	0	385,000,000	385,000,000	
	Total	0.00	0	0	385,000,000	385,000,000	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FED REIMB ALLOWANCE								
CORE								
PROGRAM DISTRIBUTIONS	688,604,798	0.00	385,000,000	0.00	385,000,000	0.00	385,000,000	0.00
TOTAL - PD	688,604,798	0.00	385,000,000	0.00	385,000,000	0.00	385,000,000	0.00
GRAND TOTAL	\$688,604,798	0.00	\$385,000,000	0.00	\$385,000,000	0.00	\$385,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$688,604,798	0.00	\$385,000,000	0.00	\$385,000,000	0.00	\$385,000,000	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Federal Reimbursement Allowance (FRA)

Program is found in the following core budget(s): Federal Reimbursement Allowance (FRA)

1. What does this program do?

PROGRAM SYNOPSIS: Provides ongoing reimbursement for hospital services and managed care premiums provided to Medicaid clients and the uninsured.

The FRA program provides payments for hospital inpatient services, outpatient services, managed care capitated payments and 1115 Waiver services (using the FRA assessment as general revenue equivalent). The FRA program supplements payments for the cost of providing care to Medicaid recipients under Title XIX of the Social Security Act and to the uninsured. Hospitals are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent and when used to make valid Medicaid payments, earns federal dollars. These earnings fund the FRA program.

Currently 142 hospitals participate in the FRA program. The current FRA assessment for fiscal year 2007 is 5.83% of total operating revenue less tax revenue/other government appropriations, plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The financial data is required to be submitted by the hospitals to the Missouri Department of Health and Senior Services. If the pertinent information is not available through the DHSS hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report. The program generates funding that is used to fund Medicaid programs.

The FRA program reimburses hospitals for certain cost as outlined below:

- Higher Inpatient Per Diems - Higher per diems were granted in October 1992 when the FRA program started. At that time, rates for the general plan hospitals were rebased to the 1990 cost reports. In April 1998, hospitals were rebased to the 1995 cost reports.
- Increased Outpatient Payment - 20% of outpatient costs are made through FRA funding. An outpatient prospective reimbursement methodology was implemented on July 1, 2002.
- Direct Medicaid Payments - The hospital receives additional lump sum payments to cover their unreimbursed costs for providing services to Medicaid patients. These payments, along with per diem payments, provide 100% of the cost for Medicaid recipients.
- Uninsured Add-on - Payments for the cost of providing services to patients that do not have insurance (charity care and bad debts). For FY 2006, reimbursement for the uninsured cost was at 90% for non-Safety Net Hospitals and 100% for acute care Safety Net Hospital licensed for more than 50 beds or operated by DMH.
- Utilization Adjustment - This payment includes the utilization adjustment to recognize the increased cost per Medicaid patient day because of the reduction in total patient days caused by the implementation of MC+ Managed Care.
- Upper Payment Limit.
- Enhanced GME.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.453; Federal law: Social Security Act Section 1903(w); Federal Regulation: 42 CFR 443 Subpart B

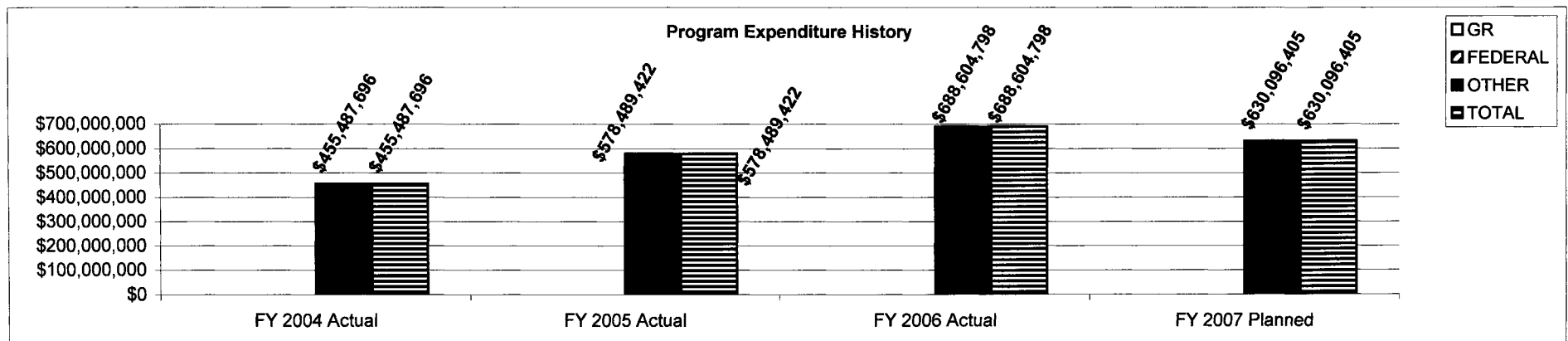
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%. The hospital assessments serve as the general revenue equivalent to earn Medicaid federal reimbursement.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

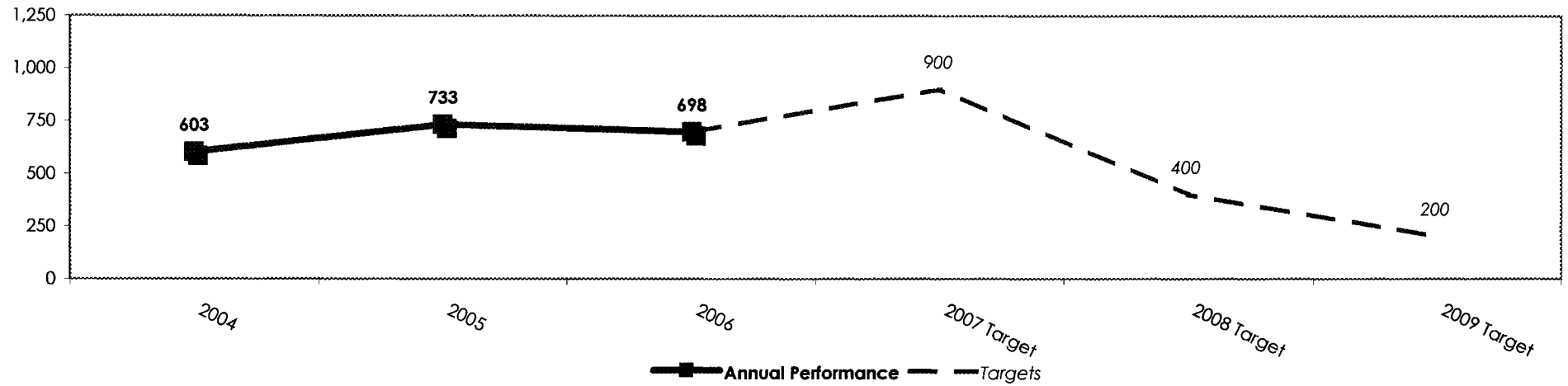


6. What are the sources of the "Other" funds?

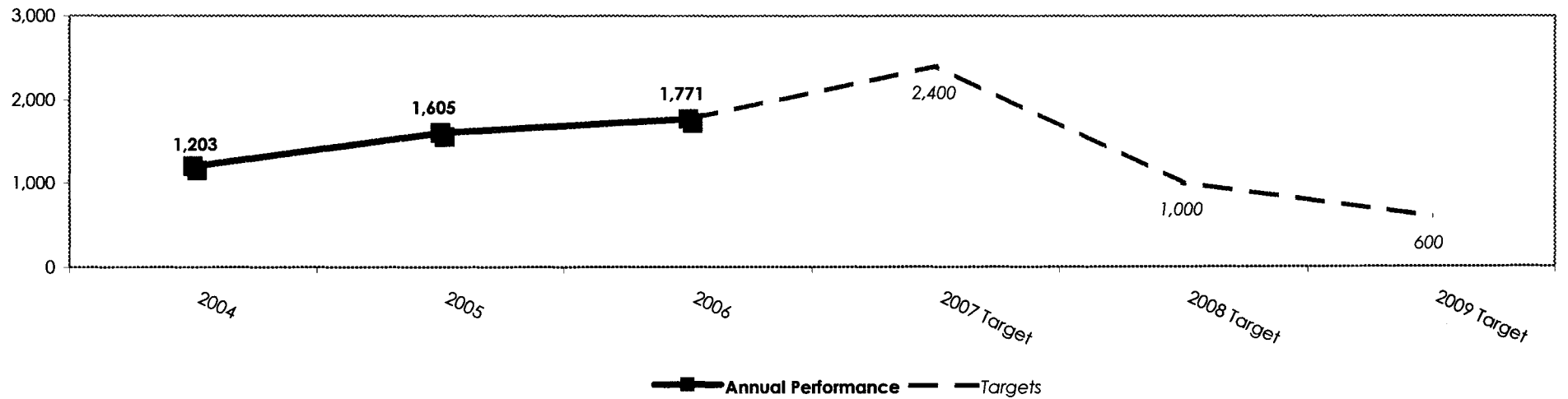
Federal Reimbursement Allowance Fund (0142)

7a. Provide an effectiveness measure.

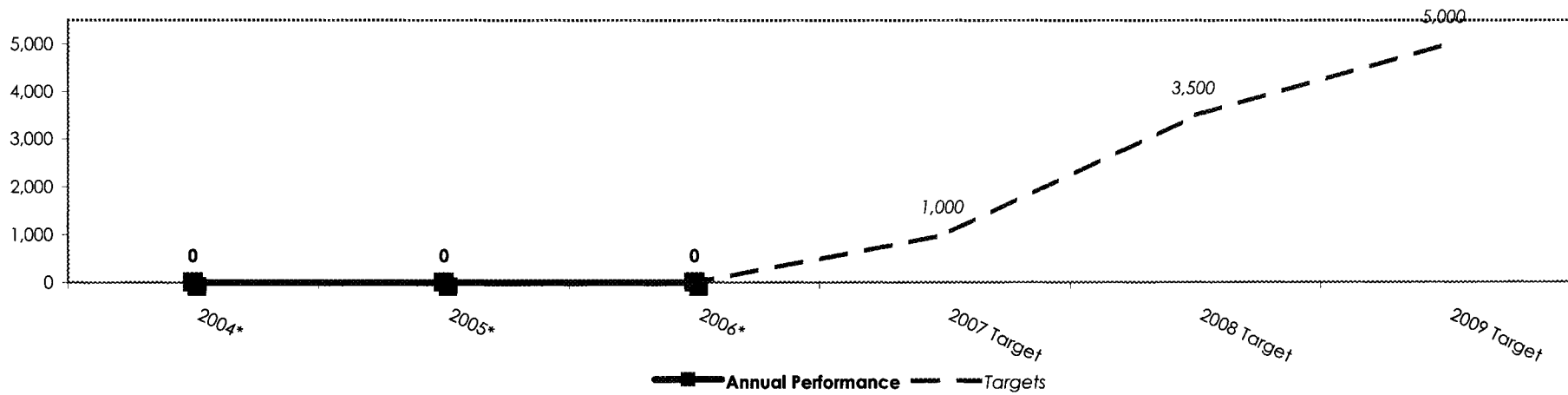
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

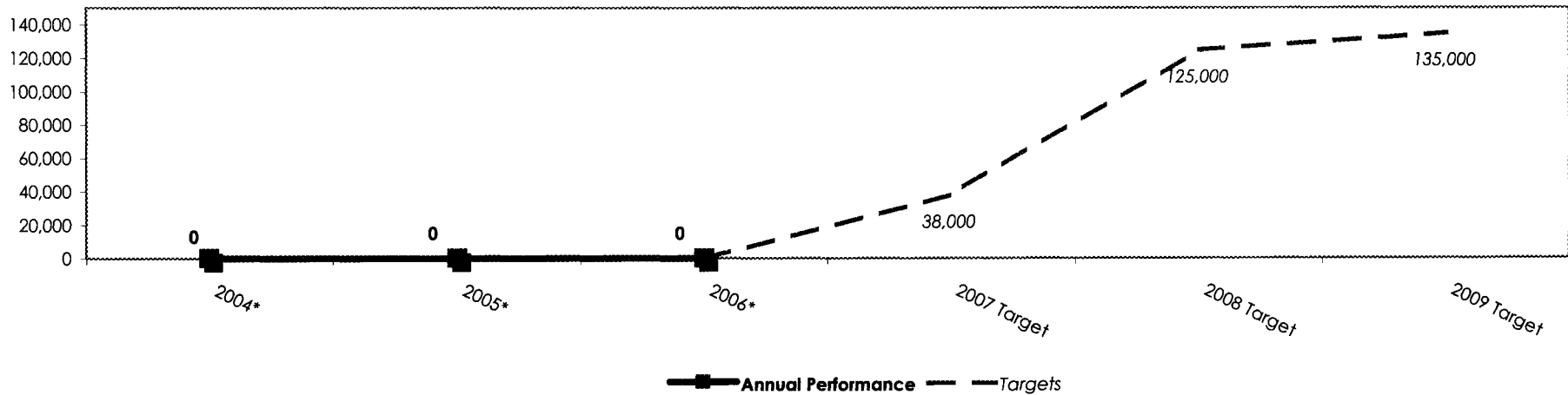


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

FRA Tax Assessments Revenues Obtained	
SFY	
2004	\$552.3 mil
2005	\$636.1 mil
2006	\$764.3 mil
2007	\$823.4 mil estimated
2008	\$809 mil estimated
2009	\$809 mil estimated

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

FRA payments are made on behalf of Medicaid eligibles and the uninsured accessing hospital services.

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 51**

Department: Social Services
Division: Medical Services
DI Name: FRA Authority Adjustment

Budget Unit: 90553C

DI#: 1886041

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			367,000,000	367,000,000
TRF				
Total			367,000,000	367,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD			367,000,000	367,000,000
TRF				
Total			367,000,000	367,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Increase Budget Authority	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

This funding is requested to increase budget authority to align the appropriation with estimated expenditures.

Providing health care services in the most efficient manner helps maintain quality of services and access to those services. In addition, the cost of health care continues to increase dramatically due to inflation, utilization of health care services and in the number of individuals accessing these services. Continued federal scrutiny of Medicaid funding increases the state's need to control costs while ensuring access to quality health care. To ensure that recipients receive quality care and to control the use of state funds, the Federal Reimbursement Allowance (FRA) program provides payments (as a general revenue equivalent) for hospital services under Title XIX of the Social Security Act.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one times and how those amounts were calculated.)

It is estimated that almost \$752 million will be paid from the FRA appropriation. The FRA Core is \$385 million with an "E". An additional \$367 million is requested to align the appropriation with estimated expenditures.

FY 08 Payment	\$752,000,000	
FY 07 Appropriation	\$385,000,000	
Request	\$367,000,000	Federal Funds

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions					367,000,000		367,000,000		
Total PSD	0		0		367,000,000		367,000,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	367,000,000	0.0	367,000,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions					367,000,000		367,000,000		
Total PSD	0		0		367,000,000		367,000,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	367,000,000	0.0	367,000,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

FRA Tax Assessments Revenues Obtained	
SFY	
2004	\$552.3 mil
2005	\$636.1 mil
2006	\$764.3 mil
2007	\$823.4 mil estimated
2008	\$809 mil estimated
2009	\$809 mil estimated

6c. Provide the number of clients/individuals served, if applicable.

Eligibles:

FRA payments are made on behalf of Medicaid eligibles and the uninsured accessing hospital services.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FED REIMB ALLOWANCE								
Adjust to Actual Activity - 1886041								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	367,000,000	0.00	367,000,000	0.00
TOTAL - PD	0	0.00	0	0.00	367,000,000	0.00	367,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$367,000,000	0.00	\$367,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$367,000,000	0.00	\$367,000,000	0.00

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: GR to FRA Transfer Increase

Budget Unit: 90840C

DI#: 1886067

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF	270,000,000			270,000,000
Total	270,000,000			270,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF	270,000,000			270,000,000
Total	270,000,000			270,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: GR Transfer	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

This funding is requested to increase the amount that is transferred from General Revenue to the Federal Reimbursement Allowance Fund.

Providing health care services in the most efficient manner helps maintain quality of services and access to those services. In addition, the cost of health care continues to increase dramatically due to inflation, utilization of health care services and in the number of individuals accessing these services. Continued federal scrutiny of Medicaid funding increases the state's need to control costs while ensuring access to quality health care. To ensure that recipients receive quality care and to control the use of state funds, the Federal Reimbursement Allowance (FRA) program provides payments (as a general revenue equivalent) for hospital services under Title XIX of the Social Security Act.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The GR share is being increased to more accurately reflect current expenditures levels. The transfer between GR and FRA occurs on the payroll date and the transfer is reversed on the same day as a payroll/accounting function.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers	270,000,000						270,000,000		
Total TRF	270,000,000		0		0		270,000,000		0
Grand Total	270,000,000	0.0	0	0.0	0	0.0	270,000,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

FRA Tax Assessments Revenues Obtained	
SFY	
2004	\$552.3 mil
2005	\$636.1 mil
2006	\$764.3 mil
2007	\$823.4 mil estimated
2008	\$809 mil estimated
2009	\$809 mil estimated

6c. Provide the number of clients/individuals served, if applicable.

Eligibles:

FRA payments are made on behalf of Medicaid eligibles and the uninsured accessing hospital services.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
GR FRA-TRANSFER								
GR to FRA Transfer Increase - 1886067								
FUND TRANSFERS	0	0.00	0	0.00	270,000,000	0.00	270,000,000	0.00
TOTAL - TRF	0	0.00	0	0.00	270,000,000	0.00	270,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$270,000,000	0.00	\$270,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$270,000,000	0.00	\$270,000,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: FRA to GR Transfer Increase

Budget Unit: 90845C

DI#: 1886068

1. AMOUNT OF REQUEST

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF			270,000,000	270,000,000
Total			270,000,000	270,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF			270,000,000	270,000,000
Total			270,000,000	270,000,000
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: FRA Transfer	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

This funding is requested to increase the amount that is transferred from Federal Reimbursement Allowance Fund to General Revenue.

Providing health care services in the most efficient manner helps maintain quality of services and access to those services. In addition, the cost of health care continues to increase dramatically due to inflation, utilization of health care services and in the number of individuals accessing these services. Continued federal scrutiny of Medicaid funding increases the state's need to control costs while ensuring access to quality health care. To ensure that recipients receive quality care and to control the use of state funds, the Federal Reimbursement Allowance (FRA) program provides payments (as a general revenue equivalent) for hospital services under Title XIX of the Social Security Act.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The FRA share is being increased to more accurately reflect current expenditure levels. The transfer between FRA and GR occurs on the payroll date and the transfer is reversed on the same day as a payroll/accounting function.

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers					270,000,000		270,000,000		
Total TRF	0		0		270,000,000		270,000,000		0
Grand Total	0	0.0	0	0.0	270,000,000	0.0	270,000,000	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS

Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

FRA Tax Assessments Revenues Obtained	
SFY	
2004	\$552.3 mil
2005	\$636.1 mil
2006	\$764.3 mil
2007	\$823.4 mil estimated
2008	\$809 mil estimated
2009	\$809 mil estimated

6c. Provide the number of clients/individuals served, if applicable.

Eligibles:

FRA payments are made on behalf of Medicaid eligibles and the uninsured accessing hospital services.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
FED REIMBURSE ALLOW-TRANSFER								
FRA to GR Transfer Increase - 1886068								
FUND TRANSFERS	0	0.00	0	0.00	270,000,000	0.00	270,000,000	0.00
TOTAL - TRF	0	0.00	0	0.00	270,000,000	0.00	270,000,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$270,000,000	0.00	\$270,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$270,000,000	0.00	\$270,000,000	0.00

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DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	
HEALTH CARE ACCESS									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	521,186	0.00	699,444	0.00	683,499	0.00	683,499	0.00	
TITLE XIX-FEDERAL AND OTHER	1,407,234	0.00	1,696,517	0.00	1,696,517	0.00	1,696,517	0.00	
FEDERAL REIMBURSEMENT ALLOWANCE	138,203	0.00	167,756	0.00	167,756	0.00	167,756	0.00	
PHARMACY REIMBURSEMENT ALLOWAN	30,411	0.00	30,411	0.00	30,411	0.00	30,411	0.00	
TOTAL - PD	2,097,034	0.00	2,594,128	0.00	2,578,183	0.00	2,578,183	0.00	
TOTAL	2,097,034	0.00	2,594,128	0.00	2,578,183	0.00	2,578,183	0.00	
Medicaid Caseload Growth - 1886033									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	19,903	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	32,779	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	52,682	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	52,682	0.00	0	0.00	
Pharmacy PMPM Increase - 1886034									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	46,693	0.00	35,042	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	76,899	0.00	57,710	0.00	
TOTAL - PD	0	0.00	0	0.00	123,592	0.00	92,752	0.00	
TOTAL	0	0.00	0	0.00	123,592	0.00	92,752	0.00	
FMAP - 1886035									
PROGRAM-SPECIFIC									
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	15,945	0.00	15,945	0.00	
TOTAL - PD	0	0.00	0	0.00	15,945	0.00	15,945	0.00	
TOTAL	0	0.00	0	0.00	15,945	0.00	15,945	0.00	
Physician-Related Rate Incr - 1886058									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	11,871	0.00	

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	19,551	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	31,422	0.00
TOTAL	0	0.00	0	0.00	0	0.00	31,422	0.00
Health Risk Appraisals - 1886060								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	235,298	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	387,513	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	622,811	0.00
TOTAL	0	0.00	0	0.00	0	0.00	622,811	0.00
GRAND TOTAL	\$2,097,034	0.00	\$2,594,128	0.00	\$2,770,402	0.00	\$3,341,113	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Health Care Access (1115 Waiver)

Budget Unit: 90554C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE					EE				
PSD	683,499	1,696,517	198,167	2,578,183	PSD	683,499	1,696,517	198,167	2,578,183
TRF					TRF				
Total	683,499	1,696,517	198,167	2,578,183	Total	683,499	1,696,517	198,167	2,578,183
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)
Pharmacy Reimbursement Allowance Fund (0144)

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)
Pharmacy Reimbursement Allowance Fund (0144)

Note: An "E" is requested for Federal Fund authority.

Note: An "E" is requested for Federal Fund authority.

2. CORE DESCRIPTION

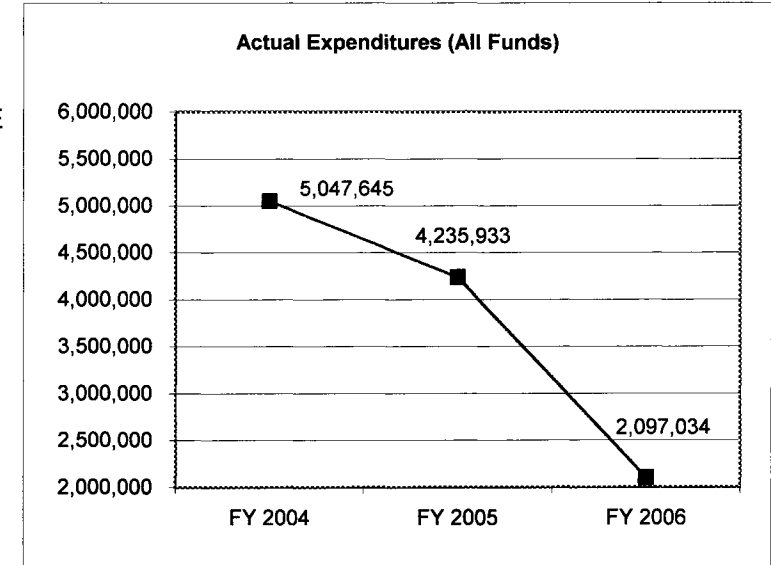
This core request is for ongoing funding for health care services provided to Medicaid clients covered through the 1115 Waiver. Funding for this core is used to provide coverage for women's health services.

3. PROGRAM LISTING (list programs included in this core funding)

Health Care Access - 1115 Waiver Adults

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	5,875,924	5,476,044	2,720,243	2,594,128 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	5,875,924	5,476,044	2,720,243	N/A
Actual Expenditures (All Funds)	5,047,645	4,235,933	2,097,034	N/A
Unexpended (All Funds)	828,279	1,240,111	623,209	N/A
Unexpended, by Fund:				
General Revenue	552,455	0	176,332	N/A
Federal	1	1,184,547	417,324	N/A
Other	275,823	55,564	29,553	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" for Federal Fund for FY 2005 thru FY 2007.

(1) Agency reserve of \$200,000 empty FRA authority. Decrease of \$750,000 to FY 05 Health Care Access appropriation based on FY 04 lapse. Expenditures of \$369,721 paid from Supplemental Pool.

(2) Transitional Medical Assistance reduced from two years to one year.

(3) Lapse of \$176,332 in GR is agency reserve; \$417,324 in Federal; and \$29,553 in FRA. SB 539 eliminated the remaining year of Transitional Medical Assistance.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

HEALTH CARE ACCESS

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			PD	0.00	699,444	1,696,517	198,167	2,594,128	
			Total	0.00	699,444	1,696,517	198,167	2,594,128	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1712	4511	PD	0.00	(15,945)	0	0	(15,945)	FMAP Adjustment
NET DEPARTMENT CHANGES				0.00	(15,945)	0	0	(15,945)	
DEPARTMENT CORE REQUEST									
			PD	0.00	683,499	1,696,517	198,167	2,578,183	
			Total	0.00	683,499	1,696,517	198,167	2,578,183	
GOVERNOR'S RECOMMENDED CORE									
			PD	0.00	683,499	1,696,517	198,167	2,578,183	
			Total	0.00	683,499	1,696,517	198,167	2,578,183	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
HEALTH CARE ACCESS								
CORE								
PROGRAM DISTRIBUTIONS	2,097,034	0.00	2,594,128	0.00	2,578,183	0.00	2,578,183	0.00
TOTAL - PD	2,097,034	0.00	2,594,128	0.00	2,578,183	0.00	2,578,183	0.00
GRAND TOTAL	\$2,097,034	0.00	\$2,594,128	0.00	\$2,578,183	0.00	\$2,578,183	0.00
GENERAL REVENUE	\$521,186	0.00	\$699,444	0.00	\$683,499	0.00	\$683,499	0.00
FEDERAL FUNDS	\$1,407,234	0.00	\$1,696,517	0.00	\$1,696,517	0.00	\$1,696,517	0.00
OTHER FUNDS	\$168,614	0.00	\$198,167	0.00	\$198,167	0.00	\$198,167	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Health Care Access (1115 Waiver-Adults)

Program is found in the following core budget(s): Health Care Access (1115 Waiver-Adults)

1. What does this program do?

PROGRAM SYNOPSIS: Provides funding for health care services to Medicaid clients covered by the 1115 waiver and its expansion. The only Medicaid clients that remain covered through the 1115 waiver are the Women's Health Services group. Other populations lost coverage as a result of a core reduction in SFY-2003 and SFY-2006.

Under the 1115 Waiver, uninsured women losing their Medicaid eligibility 60 days after the birth of their child are eligible for women's health services only for one year under the Medicaid for Pregnant Women program. Women's health services are defined as:

- Pelvic exams and pap tests
- Sexually transmitted disease testing and treatment
- Family planning counseling/education on various methods of birth control
- Department of Health and Human Services approved methods of contraception
- Drugs, supplies or devices related to the women's health services described above when they are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements.)

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.040; Federal law: Social Security Act Sections 1115 and 1923(a)-(f); Federal Regulations: 42 CFR 438 and 433 Subpart B and 412.106

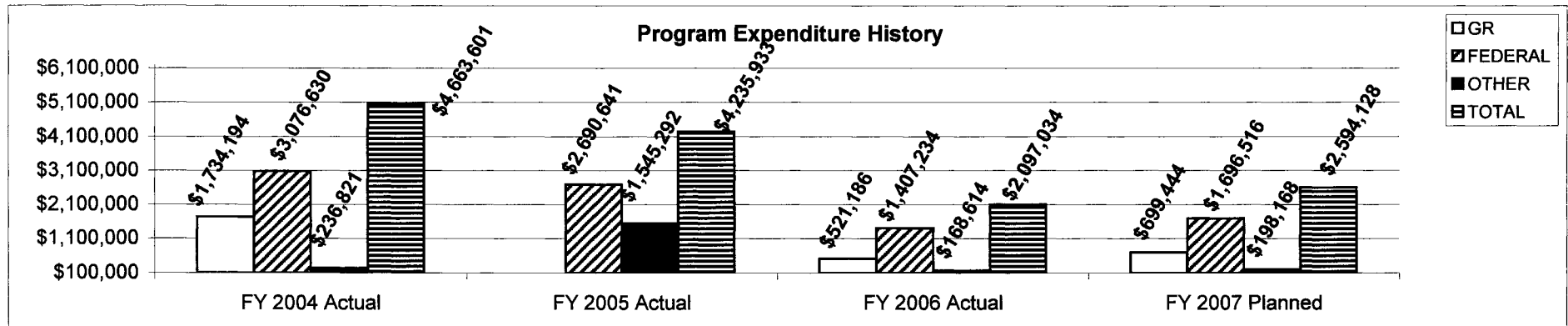
3. Are there federal matching requirements? If yes, please explain.

Most of the Women's Health Services are eligible for an enhanced 90% federal match, requiring a state match of only 10%. The remaining services are matched at the federal medical assistance percentage (FMAP) calculated for Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Missouri's FMAP for FY08 for these remaining services is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

The Federal Reimbursement Allowance Fund (0142), Pharmacy Reimbursement Allowance Fund (0144) and the Intergovernmental Transfer Fund (0163) in FY04 and FY05.

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Services are available for Women's Health Services.

Women's Health Services		
SFY	Actual	Projected
2004	9,511	
2005	10,025	
2006	12,227	
2007		12,542
2008		12,866
2009		13,198

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit

Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	18,781,285	0.00	23,027,183	0.00	22,436,895	0.00	22,436,895	0.00
TITLE XIX-FEDERAL AND OTHER	83,969,410	0.00	102,954,275	0.00	102,954,275	0.00	102,954,275	0.00
PHARMACY REBATES	225,430	0.00	225,430	0.00	225,430	0.00	225,430	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	6,819,864	0.00	7,719,204	0.00	7,719,204	0.00	7,719,204	0.00
PHARMACY REIMBURSEMENT ALLOWAN	201,394	0.00	201,394	0.00	201,394	0.00	201,394	0.00
MEDICAID MNG CARE ORG REIMB AL	891,710	0.00	1,071,200	0.00	1,071,200	0.00	1,071,200	0.00
HEALTH INITIATIVES	1,475,426	0.00	5,375,576	0.00	5,375,576	0.00	5,375,576	0.00
PREMIUM	1,828,215	0.00	6,000,000	0.00	6,000,000	0.00	6,000,000	0.00
TOTAL - PD	114,192,734	0.00	146,574,262	0.00	145,983,974	0.00	145,983,974	0.00
TOTAL	114,192,734	0.00	146,574,262	0.00	145,983,974	0.00	145,983,974	0.00
Pharmacy PMPM Increase - 1886034								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	457,662	0.00	343,461	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,272,629	0.00	955,067	0.00
TOTAL - PD	0	0.00	0	0.00	1,730,291	0.00	1,298,528	0.00
TOTAL	0	0.00	0	0.00	1,730,291	0.00	1,298,528	0.00
Managed Care Rate Increase - 1886040								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	1,310,988	0.00	1,310,988	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,645,487	0.00	3,645,487	0.00
TOTAL - PD	0	0.00	0	0.00	4,956,475	0.00	4,956,475	0.00
TOTAL	0	0.00	0	0.00	4,956,475	0.00	4,956,475	0.00
FMAP - 1886035								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	590,288	0.00	590,288	0.00
TOTAL - PD	0	0.00	0	0.00	590,288	0.00	590,288	0.00
TOTAL	0	0.00	0	0.00	590,288	0.00	590,288	0.00

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	564,655	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	1,570,146	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,134,801	0.00
TOTAL	0	0.00	0	0.00	0	0.00	2,134,801	0.00
CHIP Affordability - 1886059								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	2,067,688	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	5,749,659	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,817,347	0.00
TOTAL	0	0.00	0	0.00	0	0.00	7,817,347	0.00
Health Risk Appraisals - 1886060								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	674,295	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	1,875,023	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	2,549,318	0.00
TOTAL	0	0.00	0	0.00	0	0.00	2,549,318	0.00
GRAND TOTAL	\$114,192,734	0.00	\$146,574,262	0.00	\$153,261,028	0.00	\$165,330,731	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: CHIP (1115 Waiver--Children)

Budget Unit: 90556C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	22,436,895	102,954,275	20,592,804	145,983,974
TRF				
Total	22,436,895	102,954,275	20,592,804	145,983,974
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)
Medicaid Managed Care Organization Reimb Allowance Fund (0160)
Health Initiatives Fund (HIF) (0275)
Pharmacy Rebates Fund (0114)
Pharmacy Reimbursement Allowance Fund (0144)
Premium Fund (0885)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	22,436,895	102,954,275	20,592,804	145,983,974
TRF				
Total	22,436,895	102,954,275	20,592,804	145,983,974
FTE				0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)
Medicaid Managed Care Organization Reimb Allowance Fund (0160)
Health Initiatives Fund (HIF) (0275)
Pharmacy Rebates Fund (0114)
Pharmacy Reimbursement Allowance Fund (0144)
Premium Fund (0885)

2. CORE DESCRIPTION

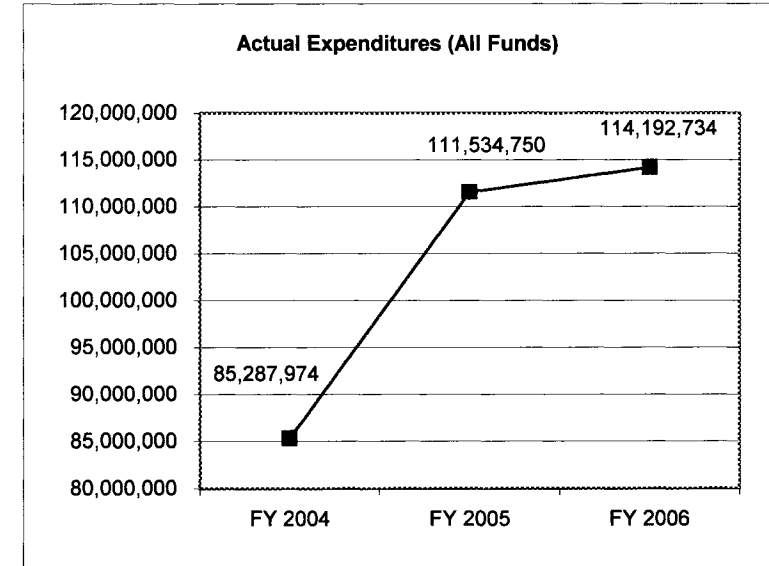
This core request is for ongoing funding for health care services provided to Medicaid clients covered through the 1115 Waiver. The State Children's Health Insurance Program (SCHIP) Title XXI funds are utilized for this expanded Medicaid population. Funding for this core is used to provide coverage for uninsured children.

3. PROGRAM LISTING (list programs included in this core funding)

Children's Health Insurance Program (CHIP)

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	86,138,915	112,243,620	137,716,363	146,574,262
Less Reverted (All Funds)	(149,975)	(151,443)	(156,113)	N/A
Budget Authority (All Funds)	85,988,940	112,092,177	137,560,250	N/A
Actual Expenditures (All Funds)	85,287,974	111,534,750	114,192,734	N/A
Unexpended (All Funds)	700,966	557,427	23,367,516	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	14,544,675	N/A
Other	700,966	557,427	8,822,841	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Agency reserve of \$700,000 is excess Premium Fund authority. Expenditures of \$16,345,048 paid from the Supplemental Pool.

(2) Agency reserve of \$550,000 in Premium Fund. Expenditures of \$3,399,176 paid from the Supplemental Pool.

(3) Agency reserve of \$4,105,257 is excess Premium Fund authority. Lapses of \$3,572,226 in HIF; \$14,544,674 in Federal; \$899,340 in FRA; \$179,490 in MC-FRA and \$66,528 in Premium Fund due to SB 539 changes in CHIP premium structure.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S HEALTH INS PROGRAM

5. CORE RECONCILIATION DETAIL

			Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES									
			PD	0.00	23,027,183	102,954,275	20,592,804	146,574,262	
			Total	0.00	23,027,183	102,954,275	20,592,804	146,574,262	
DEPARTMENT CORE ADJUSTMENTS									
Core Reduction	1713	2866	PD	0.00	(590,288)	0	0	(590,288)	FMAP Adjustment
NET DEPARTMENT CHANGES				0.00	(590,288)	0	0	(590,288)	
DEPARTMENT CORE REQUEST									
			PD	0.00	22,436,895	102,954,275	20,592,804	145,983,974	
			Total	0.00	22,436,895	102,954,275	20,592,804	145,983,974	
GOVERNOR'S RECOMMENDED CORE									
			PD	0.00	22,436,895	102,954,275	20,592,804	145,983,974	
			Total	0.00	22,436,895	102,954,275	20,592,804	145,983,974	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
CORE								
PROGRAM DISTRIBUTIONS	114,192,734	0.00	146,574,262	0.00	145,983,974	0.00	145,983,974	0.00
TOTAL - PD	114,192,734	0.00	146,574,262	0.00	145,983,974	0.00	145,983,974	0.00
GRAND TOTAL	\$114,192,734	0.00	\$146,574,262	0.00	\$145,983,974	0.00	\$145,983,974	0.00
GENERAL REVENUE	\$18,781,285	0.00	\$23,027,183	0.00	\$22,436,895	0.00	\$22,436,895	0.00
FEDERAL FUNDS	\$83,969,410	0.00	\$102,954,275	0.00	\$102,954,275	0.00	\$102,954,275	0.00
OTHER FUNDS	\$11,442,039	0.00	\$20,592,804	0.00	\$20,592,804	0.00	\$20,592,804	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Children's Health Insurance Program (CHIP)

Program is found in the following core budget(s): Children's Health Insurance Program (CHIP)

1. What does this program do?

PROGRAM SYNOPSIS: Provides for eligibility for health care services to Medicaid clients covered through the 1115 Waiver. The 1115 Waiver provides coverage to uninsured children above existing Medicaid eligibility limits up to 300% of poverty.

The State Children's Health Insurance Program (Title XXI) is integrated into Missouri's expanded Medicaid coverage. This integration was made possible through the passage of Senate Bill 632 of the second regular session of the 89th General Assembly (1998). Senate Bill 632 expanded the Medicaid program for children with family incomes from 200% to 300% of the federal poverty level.

Using the 1115 Waiver, Missouri continues its commitment to improve medical care for its low income children by increasing their access to comprehensive medical services.

Eligible children must be under age 19, have a family income below 300% of the federal poverty level, be uninsured for six months or more, and have no access to other health insurance coverage for less than \$209 to \$375 per month based on family size and income. Any child identified as having special health care needs (defined as a condition which left untreated would result in the death or serious physical injury of a child) that does not have access to affordable employer-subsidized health care insurance will not be required to be without health care coverage for six months in order to be eligible for services. They also will not be subject to the waiting period as long as the child meets all other qualifications for eligibility.

Uninsured children will receive a package of benefits equal to Medicaid coverage without non-emergency medical transportation. Parents of children eligible for coverage above 150% and below 300% of the federal poverty level must show parental responsibility through the following:

- participation in immunization and wellness programs;
- furnishing the uninsured child's social security number;
- cooperation with third party insurance carriers;
- cooperation in child support cases; and
- sharing in their children's health care costs through premiums.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.631 through 208.657; Federal law: Social Security Act Sections 1115, 1923(a)-(f), and 2101 through 2110;

Federal Regulations: 42 CFR 438, 433 Subpart B and 412.106

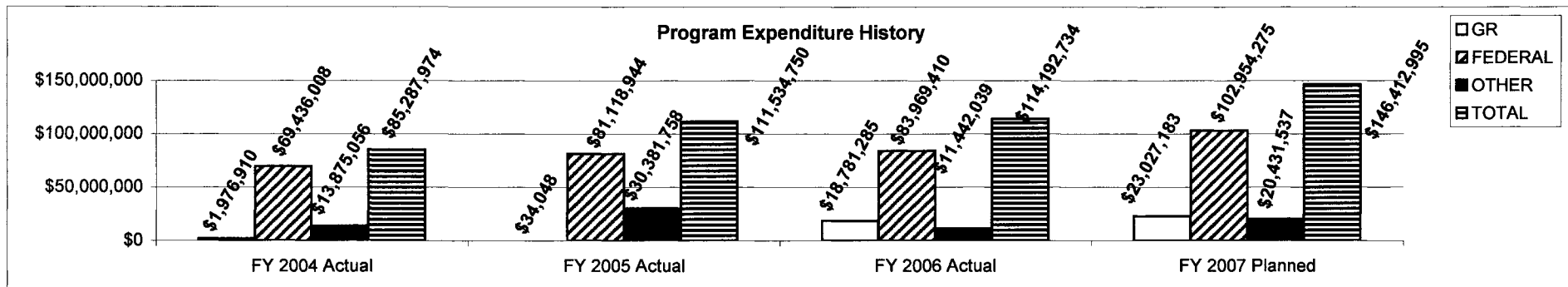
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Missouri's enhanced CHIP FMAP for FY08 is a blended 73.55% federal match. The state matching requirement for the CHIP program is 26.45%.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

Pharmacy Rebates Fund (0114), Federal Reimbursement Allowance Fund (0142), Pharmacy Reimbursement Allowance Fund (0144), Health Initiatives Fund (0275), Premium Fund (0885), and Intergovernmental Transfer (0139) were not available in FY 06. Medicaid Managed Care Organization Reimbursement Allowance Fund (0160) was new in FY 06. Pharmacy Rebates Fund (0114), Federal Reimbursement Allowance Fund (0142), Pharmacy Reimbursement Allowance Fund (0144), Health Initiatives Fund (0275), Premium Fund (0885), and Medicaid Managed Care Organization Reimbursement Allowance Fund (0160) were available in FY 07 and comprise the total of "other" funds.

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Children above existing Title XIX
Medicaid eligibility up to 300% of
poverty.

Children Receiving Services by Percent of Federal Poverty Level								
SFY	101-150%		151-185%		186-225%		226-300%*	
	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected
2004	41,210		28,638		17,463		1,582	
2005	42,075		29,239		19,062		1,789	
2006	41,396	47,240	11,789	20,866	6,603	10,604	2,141	2,737
2007		41,396		11,789		6,603		2,141
2008		41,396		11,789		6,603		2,141
2009		41,396		11,789		6,603		2,141

*Reflects only those paying a premium. As of September, 2005 premiums are required from families with income from 151-300% FPL.

7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM
RANK: 999**

Department: Social Services
Division: Medical Services
DI Name: CHIP Affordability

Budget Unit: 90556C
DI#: 1886059

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	2,067,688	5,749,659		7,817,347
TRF				
Total	2,067,688	5,749,659		7,817,347

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input checked="" type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Changes the definition of "affordable employer-sponsored health care insurance or other affordable health care coverage" for families in the Children's Health Insurance Program (CHIP).

The affordability test is based on the family size and family income. The income guidelines include the following ranges: over 150% to 185% of the Federal Poverty Level (FPL) ; over 185% to 225% of the FPL and over 225% to 300% of the FPL. The new affordability test will be based on 3%, 4% or 5% of the family income.

State Statute: RSMo. 208.631 through 208.657; Federal Law: Social Security Act Sections 1115, 1923(a)-(f), and 2101 through 2110
Federal Regulation: 42 CFR 438, 433 Subpart B and 412.106.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The number of new eligibles was estimated by determining the number of eligibles in each federal poverty level group who were rejected under the current affordability standards. These eligible numbers were multiplied by the current cost per eligible. The amount of premiums that are expected to be collected from the new eligibles was estimated and deducted from the estimated cost per eligible to arrive at an estimated net cost. It is projected that 6,349 children will enter the CHIP program because of the changes in the affordability test. The projected cost is \$7,817,347.

	Total	GR	Federal
1115 Waiver - Children	7,817,347	2,067,688	5,749,659

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	2,067,688		5,749,659				7,817,347		
Total PSD	2,067,688		5,749,659		0		7,817,347		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	2,067,688	0.0	5,749,659	0.0	0	0.0	7,817,347	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

Children Receiving Services by Percent of Federal Poverty Level Under Current Affordability Standards								
SFY	101-150%		over 150-185%		over 185-225%		over 225-300%*	
	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected
2004	41,210		28,638		17,463		1,582	
2005	42,075		29,239		19,062		1,789	
2006	41,396	47,240	11,789	20,866	6,603	10,604	2,141	2,737
2007		41,396		11,789		6,603		2,141
2008		41,396		11,789		6,603		2,141
2009		41,396		11,789		6,603		2,141

*Reflects only those paying a premium. As of September, 2005 premiums are required from families with income from over 150-300% FPL.

Estimated Number of New Eligibles Under New Affordability Standards		
Fiscal Year	Federal Poverty Level	Eligibles
2008	over 150% - 225%	4,242
	over 225% - 300%	2,107

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

Participate in the Statewide Coalition consisting of leaders from the Missouri Hospital Association and the Family and Community Trust to provide outreach and enrollment.

Continue to work with community groups, local medical providers, health care associations, schools, etc. regarding access to Medicaid coverage.

Continue to work with MC+ managed care health plans to provide outreach and education to communities regarding access to MC+ coverage.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
CHILDREN'S HEALTH INS PROGRAM								
CHIP Affordability - 1886059								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	7,817,347	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	7,817,347	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$7,817,347	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$2,067,688	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$5,749,659	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

INSURANCE PREMIUM
OFFSET

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
INSURANCE PREMIUM OFFSET								
Insurance Premium Offset - 1886055								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	10,000,000	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	0	0.00	16,470,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	26,470,000	0.00
TOTAL	0	0.00	0	0.00	0	0.00	26,470,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$26,470,000	0.00

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NEW DECISION ITEM

RANK: 0

Department: Social Services
Division: Medical Services
DI Name: Insurance Premium Offset

Budget Unit: 90565C

DI#: 1886055

1. AMOUNT OF REQUEST

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				0

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE				
PSD	10,000,000	16,470,000		26,470,000
TRF				
Total	10,000,000	16,470,000		26,470,000

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

2. THIS REQUEST CAN BE CATEGORIZED AS:

<input type="checkbox"/> New Legislation	<input checked="" type="checkbox"/> X	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/>	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/>	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/>	<input type="checkbox"/> Other:	

3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Premium offsets for lower-income Missourians.

Governor Blunt's legislative and budget priorities include a commitment to reduce the number of uninsured Missourians. This budget recommendation funds premium supplements for lower-income Missourians to support Governor Blunt's priorities.

4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)

The Governor's budget recommendations include \$10.0M GR and \$16.5M federal funds for insurance premium offsets for lower income Missourians. The Department will work with its federal partners to help ensure that the state funded premium contribution is eligible to draw federal funding. The \$10.0M GR recommendation is half of a \$20.0M state contribution split over two budget years.

	Total	GR	Federal
Insurance Premium Offset	\$26,470,000	\$10,000,000	\$16,470,000

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
							0	0.0	
							0	0.0	
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
							0		
							0		
							0		
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
							0	0.0	
							0	0.0	
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
							0		
							0		
							0		
							0		
Total EE	0		0		0		0		0
Program Distributions	10,000,000		16,470,000				26,470,000		
Total PSD	10,000,000		16,470,000		0		26,470,000		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	10,000,000	0.0	16,470,000	0.0	0	0.0	26,470,000	0.0	0

6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.

6d. Provide a customer satisfaction measure, if available.

7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:

Help reduce the number of uninsured Missourians.

Help ensure that all Missourians have access to affordable health insurance.

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
INSURANCE PREMIUM OFFSET								
Insurance Premium Offset - 1886055								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	0	0.00	26,470,000	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	26,470,000	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$0	0.00	\$26,470,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$10,000,000	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$16,470,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
UNCOMPENSATED CARE								
CORE								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	24,117,673	0.00	25,000,000	0.00	25,000,000	0.00	25,000,000	0.00
TOTAL - PD	24,117,673	0.00	25,000,000	0.00	25,000,000	0.00	25,000,000	0.00
TOTAL	24,117,673	0.00	25,000,000	0.00	25,000,000	0.00	25,000,000	0.00
GRAND TOTAL	\$24,117,673	0.00	\$25,000,000	0.00	\$25,000,000	0.00	\$25,000,000	0.00

CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Uncompensated Care

Budget Unit: 90555C

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE		25,000,000		25,000,000 E
PSD				
TRF				
Total		25,000,000		25,000,000 E

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

Note: An "E" is requested for the \$25,000,000 Federal Funds

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE		25,000,000		25,000,000 E
PSD				
TRF				
Total		25,000,000		25,000,000 E

FTE 0.00

Est. Fringe	0	0	0	0
-------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

Note: An "E" is requested for the \$25,000,000 Federal Funds

2. CORE DESCRIPTION

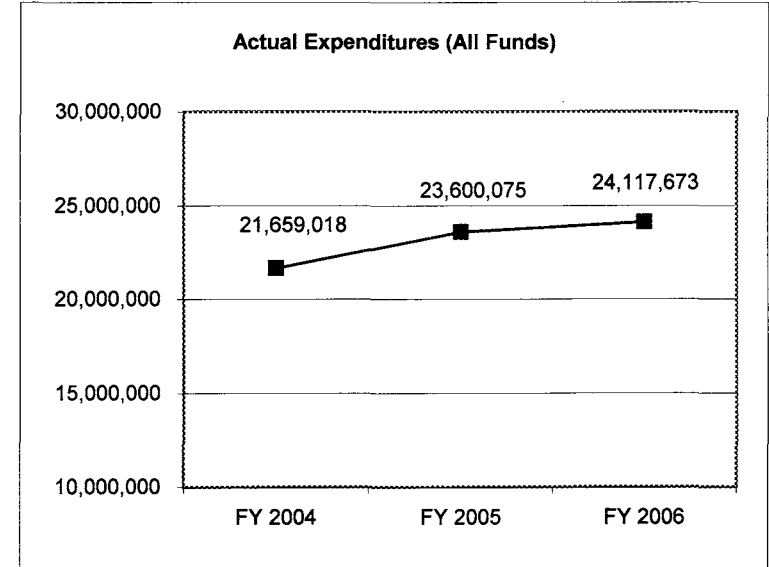
This core request is for ongoing funding to reimburse for health care services provided to the uninsured in the St. Louis region through a primary care safety net system. Funding for this core is used to maintain reimbursement at a sufficient level to ensure quality health care and provider participation.

3. PROGRAM LISTING (list programs included in this core funding)

Uncompensated Care - St. Louis Regional DSH Funding Authority

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	25,000,000	25,000,000	25,000,000	25,000,000 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	25,000,000	25,000,000	25,000,000	N/A
Actual Expenditures (All Funds)	21,659,018	23,600,075	24,117,673	N/A
Unexpended (All Funds)	3,340,982	1,399,925	882,327	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	3,340,982	1,399,925	882,327	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriations for Federal Fund for FY 2004 through FY 2007.

(1) Lapse of \$3,340,982 is excess RDFA which is reduced or increased proportionately to the DSH funding available to the state as a whole .

(2) Lapse of \$1,399,925 is excess RDFA which is reduced or increased proportionately to the DSH funding available to the state as a whole .

(3) Lapse of \$882,327 is excess RDFA which is reduced or increased proportionately to the DSH funding available to the state as a whole.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**UNCOMPENSATED CARE**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	PD	0.00	0	25,000,000	0	25,000,000	
	Total	0.00	0	25,000,000	0	25,000,000	
DEPARTMENT CORE REQUEST							
	PD	0.00	0	25,000,000	0	25,000,000	
	Total	0.00	0	25,000,000	0	25,000,000	
GOVERNOR'S RECOMMENDED CORE							
	PD	0.00	0	25,000,000	0	25,000,000	
	Total	0.00	0	25,000,000	0	25,000,000	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
UNCOMPENSATED CARE								
CORE								
PROGRAM DISTRIBUTIONS	24,117,673	0.00	25,000,000	0.00	25,000,000	0.00	25,000,000	0.00
TOTAL - PD	24,117,673	0.00	25,000,000	0.00	25,000,000	0.00	25,000,000	0.00
GRAND TOTAL	\$24,117,673	0.00	\$25,000,000	0.00	\$25,000,000	0.00	\$25,000,000	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$24,117,673	0.00	\$25,000,000	0.00	\$25,000,000	0.00	\$25,000,000	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Uncompensated Care

Program is found in the following core budget(s): Uncompensated Care

1. What does this program do?

PROGRAM SYNOPSIS: Provides ongoing funding to reimburse for health care services provided to the uninsured in St. Louis region through a primary care safety net system.

The State received approval for an 1115 Demonstration Waiver in order to make disproportionate share hospital (DSH) payments to a St. Louis Regional DSH Funding Authority (RDFA) for five years. The payments would be used to fund the recommendations of a regional health care authority to reshape and stabilize the provision of indigent health care delivery in the St. Louis area into a cohesive system. St. Louis ConnectCare has agreed to participate in the demonstration by surrendering its Missouri hospital license and moving to become an integral part of this cohesive community delivery system. The closing of an urban public hospital is always traumatic, but in this case, the plan is thoughtful and forward-looking. This waiver will be the cornerstone of building a new delivery system. The waiver expires April 2007. We are exploring other funding mechanisms to continue supporting this initiative.

ConnectCare was established in 1997 as a stop gap solution to ensure continuity in health care for St. Louis' indigent population. Despite financial and organizational obstacles, the staff and board of ConnectCare have provided primary and specialty care to St. Louis' uninsured. ConnectCare operated a 24-bed hospital with a fully staffed emergency room, four primary care clinics, two specialty clinics, and a dialysis center. The financing of ConnectCare continues to be a major issue, relying on patchwork temporary and unstable financial commitments from St. Louis City, St. Louis County, DSS, the federal Department of Health and Human Services, and community religious and philanthropic organizations. The recent financing crisis suggests that it is time to advance the provision of indigent care in St. Louis to the next evolutionary stage. Even more importantly, the provision of indigent care in the community is haphazard in that coordination between different provider systems is almost non-existent. Duplication of facilities and a heavy reliance on belated emergency room care is the by-product.

St. Louis ConnectCare is being transitioned from an inpatient to an outpatient care facility to develop a system of care for the uninsured with a strong primary care focus. This will enable the St. Louis region to transition its "safety net" system of care for the medically indigent to a viable, self-sustaining model. By making uncompensated care payments to ConnectCare, the Division of Medical Services ensures that this type of care can continue to be provided in the St. Louis Region.

Providing health care services for the indigent population of St. Louis is beyond the capabilities of any one provider, or even one group of providers. Health Care for the indigent in St. Louis City and St. Louis County is a shared responsibility. Hospital emergency rooms are the most expensive and inefficient setting in which to provide primary health care and specialty care for the uninsured. Yet hospitals are currently the only Medicaid providers to receive funding for serving uninsured Missourians. The State will make disproportionate share payments, up to a fixed amount, to pay for primary health care and specialty care in a neighborhood clinic. This will allow Missouri to move primary health care and specialty care out of an inpatient hospital facility into community clinics.

The challenge of providing adequate health care coverage to the indigent population of St. Louis will only be resolved when a partnership of the St. Louis area health care provider systems; city, county and state governments; and concerned stakeholders in the community can come together with a clear consensus of what must be accomplished. The purpose is to re-vitalize health care services in St. Louis City and St. Louis County and meld together the St. Louis area's fragmented health care services for the indigent. The goal is to develop a system of care for the uninsured with a strong primary care focus. The region must work for a regional solution to a truly regional problem: meeting the medical needs of uninsured and underinsured residents of the City of St. Louis and St. Louis County. The region needs to make significant progress toward developing stable funding for indigent health instead of relying on a current patchwork of temporary and unstable financial commitments. There is currently insufficient participation in the financing of indigent care provided in a primary care setting and a disorganized system of care. This primary care safety net system needs its own funding streams, but also needs to be well organized to streamline services, eliminate duplication, and better give its consumers the chance to reshape their health care seeking habits in a positive direction, holding promise for significant long-term improvements. The goal is to change the dynamics of the current patchwork indigent health care system to a healthy and efficient one.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1115, 1923(a)-(f); Federal Regulation: 42 CFR 412.106

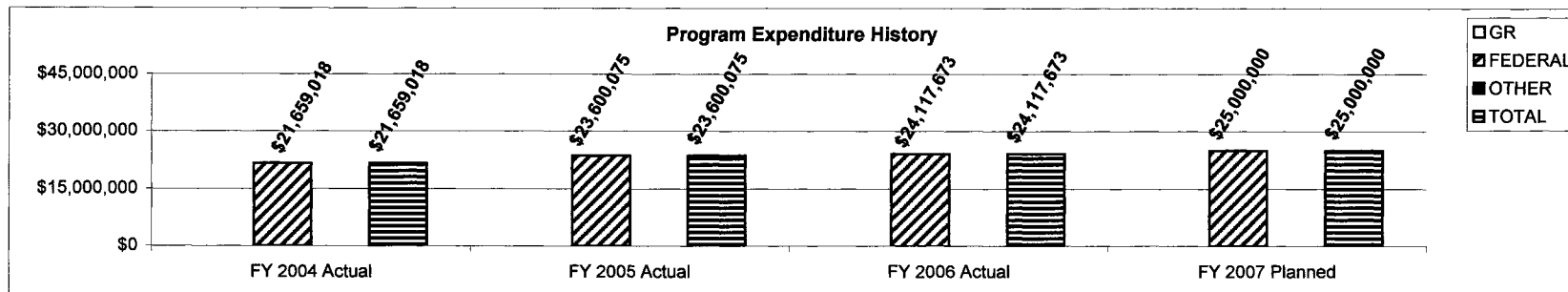
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%. The payments made to the St. Louis Regional DSH Funding Authority are allowed under the 1115 waiver. Certified public expenditures are utilized to satisfy the state matching requirement and draw down the federal funds.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITY FED REIMB AL								
CORE								
PROGRAM-SPECIFIC								
NURSING FACILITY FED REIM ALLW	202,248,332	0.00	217,000,000	0.00	213,840,231	0.00	213,840,231	0.00
TOTAL - PD	202,248,332	0.00	217,000,000	0.00	213,840,231	0.00	213,840,231	0.00
TOTAL	202,248,332	0.00	217,000,000	0.00	213,840,231	0.00	213,840,231	0.00
GRAND TOTAL	\$202,248,332	0.00	\$217,000,000	0.00	\$213,840,231	0.00	\$213,840,231	0.00

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CORE DECISION ITEM

Department: Social Services

Budget Unit: 90567C

Division: Medical Services

Appropriation: Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			213,840,231	213,840,231 E
TRF				
Total			213,840,231	213,840,231 E

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

FY 2008 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD			213,840,231	213,840,231 E
TRF				
Total			213,840,231	213,840,231 E

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Nursing Facility Federal Reimb Allowance Fund (NFRA) (0196)

Other Funds: Nursing Facility Federal Reimb Allowance Fund (NFRA) (0196)

Notes: An "E" is requested for the Nursing Facility Federal Reimbursement Allowance Fund

Notes: An "E" is requested for the Nursing Facility Federal Reimbursement Allowance Fund

2. CORE DESCRIPTION

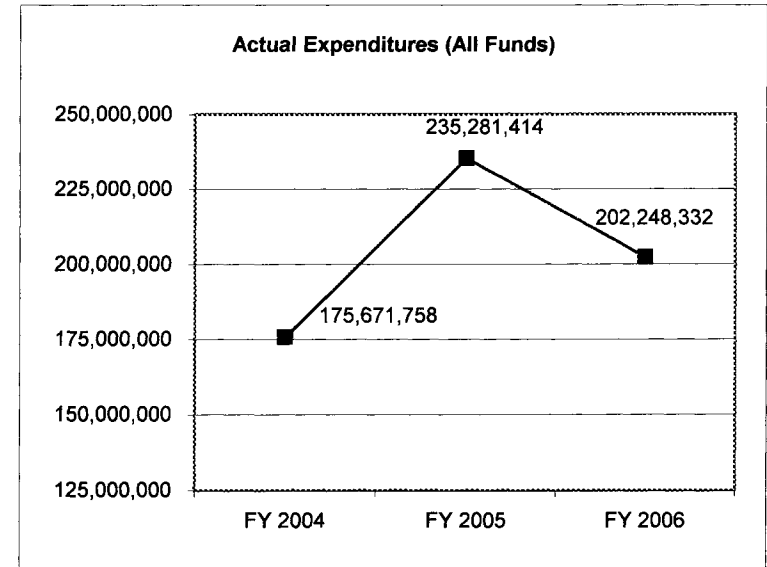
This core request is for ongoing funding for payments for long term care for Title XIX recipients. Funds from this core are used to provide enhanced payment rates for improving the quality of patient care using the Nursing Facility Federal Reimbursement Allowance under the Title XIX of the Social Security Act as General Revenue equivalent. Nursing facilities are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent, and when used to make valid Medicaid payments, earns federal dollars. These earnings fund this NFRA program appropriation.

3. PROGRAM LISTING (list programs included in this core funding)

Nursing Facilities Federal Reimbursement Allowance (NFFRA) Program

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.	
Appropriation (All Funds)	185,000,000	235,281,440	217,000,000	217,000,000	E
Less Reverted (All Funds)	0	0	0	N/A	
Budget Authority (All Funds)	185,000,000	235,281,440	217,000,000	N/A	
Actual Expenditures (All Funds)	175,671,758	235,281,414	202,248,332	N/A	
Unexpended (All Funds)	9,328,242	26	14,751,668	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	0	N/A	
Other	9,328,242	26	14,751,668	N/A	
	(1)	(2)	(3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriations for Nursing Facility Federal Reimbursement Allowance Fund for FY 2004 thru FY 2007.

(1) Lapse of \$9,328,242 is excess authority.

(2) Increase in expenditures is due to tax increase and accumulated payments from delayed State Plan Amendment approval. Tax increase was needed to fund the Medicaid rate increase.

(3) Lapse of \$14,751,668 is excess authority.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES

NURSING FACILITY FED REIMB AL

5. CORE RECONCILIATION DETAIL

				Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES				PD	0.00	0	0	217,000,000	217,000,000	
				Total	0.00	0	0	217,000,000	217,000,000	
DEPARTMENT CORE ADJUSTMENTS										
Core Reduction	3363	1606	PD	0.00	0	0	0	(3,159,769)	(3,159,769)	Core Reduction - Provider Tax Cap Reduction
NET DEPARTMENT CHANGES					0.00	0	0	(3,159,769)	(3,159,769)	
DEPARTMENT CORE REQUEST										
				PD	0.00	0	0	213,840,231	213,840,231	
				Total	0.00	0	0	213,840,231	213,840,231	
GOVERNOR'S RECOMMENDED CORE										
				PD	0.00	0	0	213,840,231	213,840,231	
				Total	0.00	0	0	213,840,231	213,840,231	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
NURSING FACILITY FED REIMB AL								
CORE								
PROGRAM DISTRIBUTIONS	202,248,332	0.00	217,000,000	0.00	213,840,231	0.00	213,840,231	0.00
TOTAL - PD	202,248,332	0.00	217,000,000	0.00	213,840,231	0.00	213,840,231	0.00
GRAND TOTAL	\$202,248,332	0.00	\$217,000,000	0.00	\$213,840,231	0.00	\$213,840,231	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$202,248,332	0.00	\$217,000,000	0.00	\$213,840,231	0.00	\$213,840,231	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments

Program is found in the following core budget(s): Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments

1. What does this program do?

PROGRAM SYNOPSIS: Provides enhanced payments for long-term care for Title XIX recipients.

The NFFRA program assesses nursing facilities in the state a fee for the privilege of doing business in the state. The funds collected by the state are used to fund the Medicaid Nursing Facility program and are used as state match for federal funding. In FY 06, approximately 550 nursing facilities were assessed, and an average of 500 nursing facilities participated in the Medicaid program and received enhanced reimbursement. The current NFFRA fee is \$8.42 per patient occupancy day.

In FY95, the Nursing Facilities Federal Reimbursement Allowance program was implemented as part of a total restructuring of reimbursement for nursing homes. Reimbursement methodologies were changed to develop a cost component system. The components are patient care, ancillary, administration, and capital. A working capital allowance, incentives and the Nursing Facility Reimbursement Allowance (NFRA) are also elements of the total reimbursement rate. Patient care includes nursing, medical supplies, activities, social services, and dietary costs. Ancillary services are therapies, barber and beauty shop, laundry, and housekeeping. Administration includes plant operation costs and administrative costs. Capital costs are reimbursed through a fair rental value methodology. The capital component includes five types of costs: rental value, return, computed interest, borrowing costs and pass through expenses. Property insurance and real estate & personal property taxes (the pass through expenses) are the only part of the capital component that is trended. The working capital allowance per diem rate is equal to 1.1 months of the total of the facility's per diem rates for the patient care, ancillary and administration cost components times the prime rate plus 2 percent. Incentives are paid to encourage patient care expenditures and cost efficiencies in administration. The patient care incentive is 10% of a facility's patient care per diem up to a maximum of 130% of the patient care median. The ancillary incentive is paid to all facilities whose costs are below the ancillary ceiling. The amount is one-half the difference between certain parameters. The multiple component incentive is allowed for facilities whose patient care and ancillary per diem are between 60 - 80% of total per diem and an additional amount is allowed for facilities with high Medicaid utilization.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 198.401; Federal law: Social Security Act Section 1903(w); Federal Regulation: 42 CFR 443, Subpart B

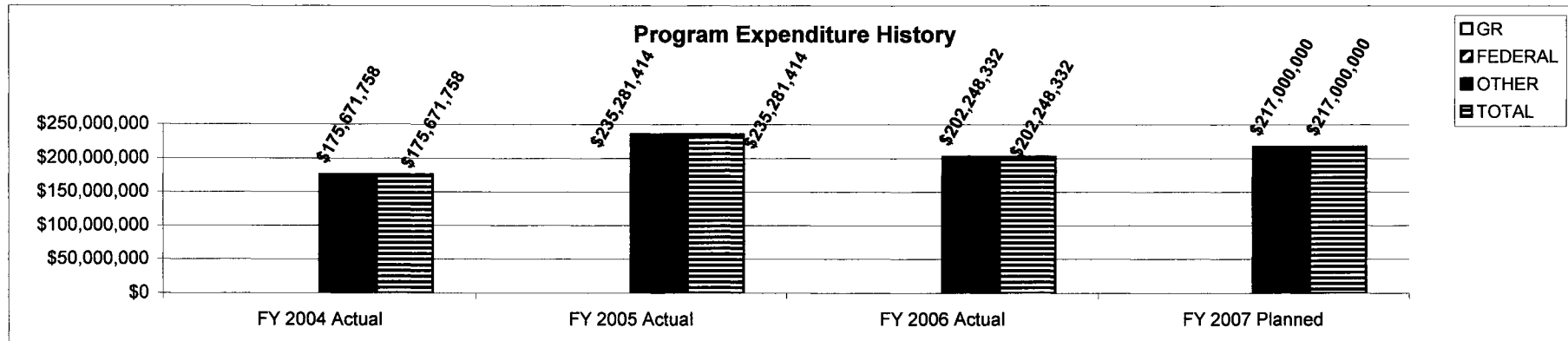
3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY08 is a blended 62.22% federal match. The state matching requirement is 37.78%. The nursing facility assessments serve as the general revenue equivalent to earn Medicaid federal reimbursement.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



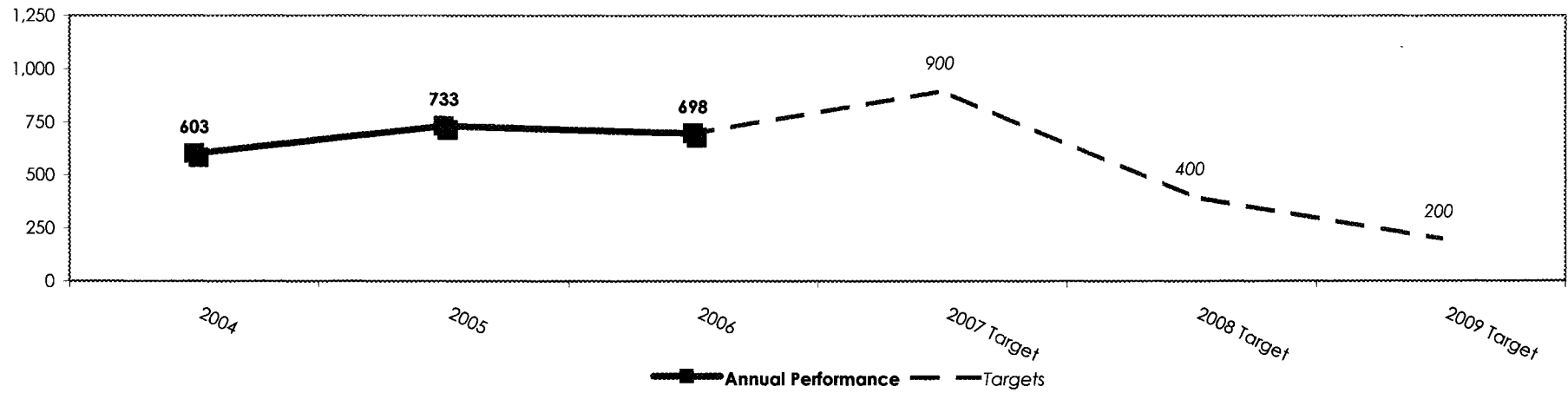
6. What are the sources of the "Other" funds?

Nursing Facility Federal Reimbursement Allowance Fund (0196)

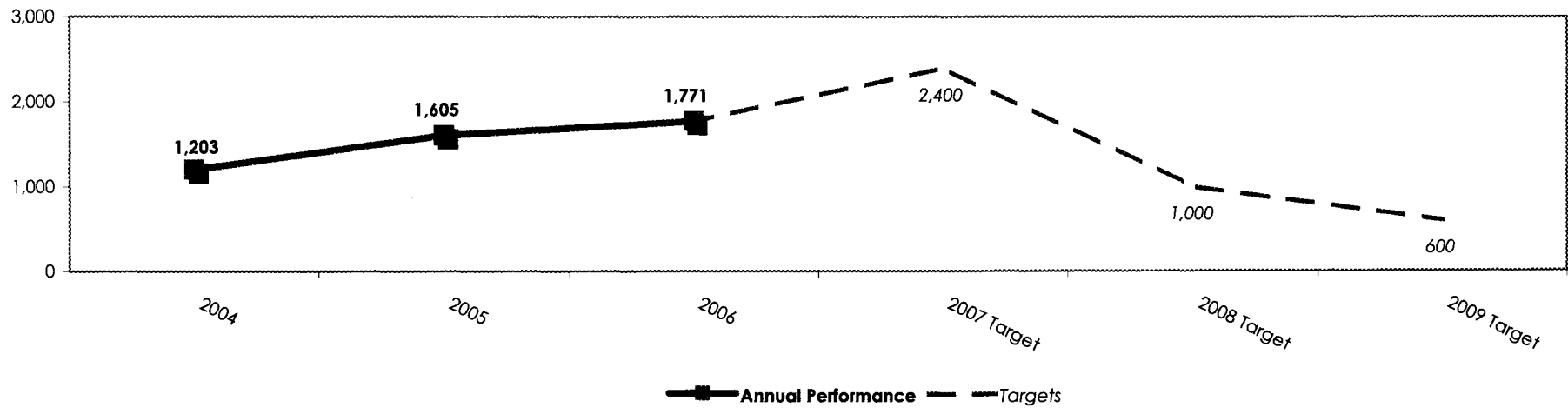
7a. Provide an effectiveness measure.

Nursing Facility Occupancy		
SFY	Actual	Projected
2004	72.5%	
2005	72.3%	
2006	72.6%	72.8%
2007		72.6%
2008		72.6%
2009		72.6%

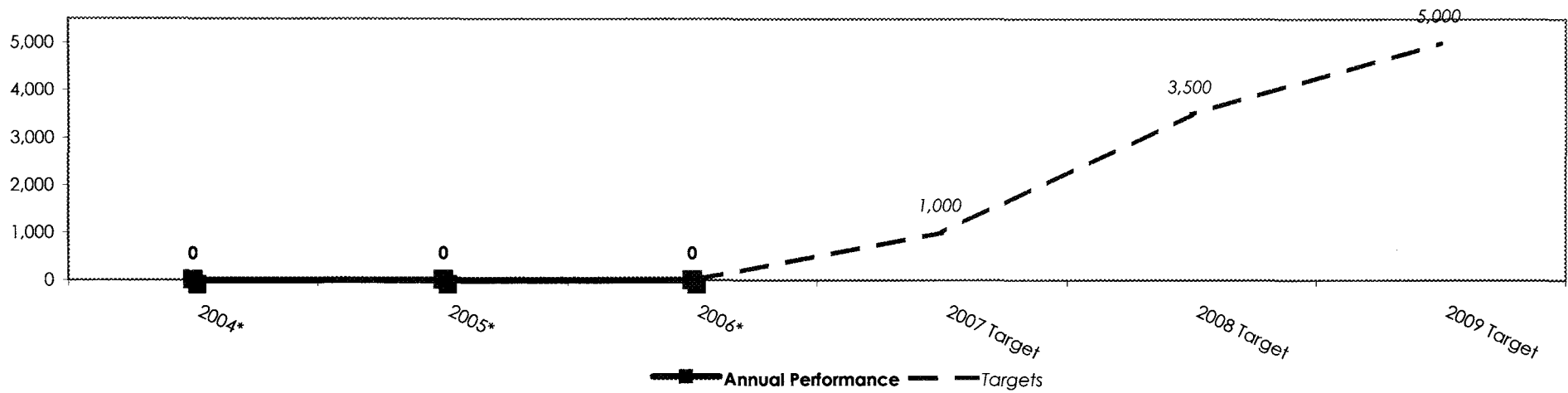
Medicaid Providers Participating in Disease Management



Medicaid/MC+ Recipients in a Disease Management Program

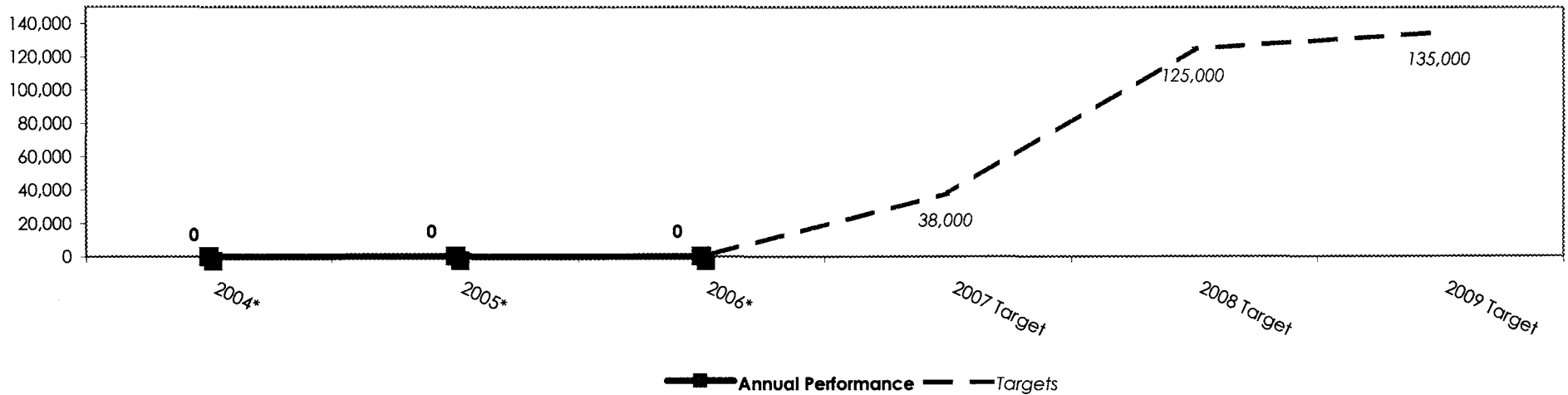


Increase Medicaid Providers Participating in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 1,000 providers during this first program year.

Increase Medicaid/MC+ Recipients in a Chronic Care Improvement Program



*The Chronic Care Improvement Program (CCIP) will begin early in Fiscal Year 2007 with an estimated 20,000 recipients participating during this first program year.

7b. Provide an efficiency measure.

NFRA Tax Assessments Revenues Obtained	
SFY	
2004	\$129.0 mil
2005	\$140.5 mil
2006	\$127.7 mil
2007	\$127.9 mil estimated
2008	\$123.7 mil estimated
2009	\$123.7 mil estimated

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Nursing Facility Federal Reimbursement Allowance
(NFFRA) payments are made on behalf of
Medicaid eligibles for long-term care services.

Average Monthly Medicaid Nursing Facility Users		
SFY	Actual	Projected
2004	24,694	25,469
2005	25,677	24,500
2006	24,842	26,447
2007		25,000
2008		25,000
2009		25,000

Paid Patient Days		
SFY	Actual	Projected
2004	8.9 mil	9.2 mil
2005	8.9 mil	9.1 mil
2006	8.8 mil	9.0 mil
2007		8.8 mil
2008		8.8 mil
2009		8.9 mil

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DESE SERVICES								
CORE								
EXPENSE & EQUIPMENT								
TITLE XIX-FEDERAL AND OTHER	2,125,870	0.00	0	0.00	2,125,000	0.00	2,125,000	0.00
TOTAL - EE	2,125,870	0.00	0	0.00	2,125,000	0.00	2,125,000	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	69,954	0.00	69,954	0.00	69,954	0.00	69,954	0.00
TITLE XIX-FEDERAL AND OTHER	33,779,772	0.00	33,299,954	0.00	31,174,954	0.00	31,174,954	0.00
TOTAL - PD	33,849,726	0.00	33,369,908	0.00	31,244,908	0.00	31,244,908	0.00
TOTAL	35,975,596	0.00	33,369,908	0.00	33,369,908	0.00	33,369,908	0.00
GRAND TOTAL	\$35,975,596	0.00	\$33,369,908	0.00	\$33,369,908	0.00	\$33,369,908	0.00

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CORE DECISION ITEM

Department: Social Services

Budget Unit: 90569C

Division: Medical Services

Appropriation: Department of Elementary and Secondary Education (DESE) Services

1. CORE FINANCIAL SUMMARY

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE		2,125,000		2,125,000	EE		2,125,000		2,125,000
PSD	69,954	31,174,954		31,244,908	PSD	69,954	31,174,954		31,244,908
TRF					TRF				
Total	69,954	33,299,954		33,369,908	Total	69,954	33,299,954		33,369,908
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

Notes: An "E" is requested for Federal Fund authority.

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

Notes: An "E" is requested for Federal Fund authority.

2. CORE DESCRIPTION

This core request is for the ongoing funding for payments for school-based administrative and school-based EPSDT services.

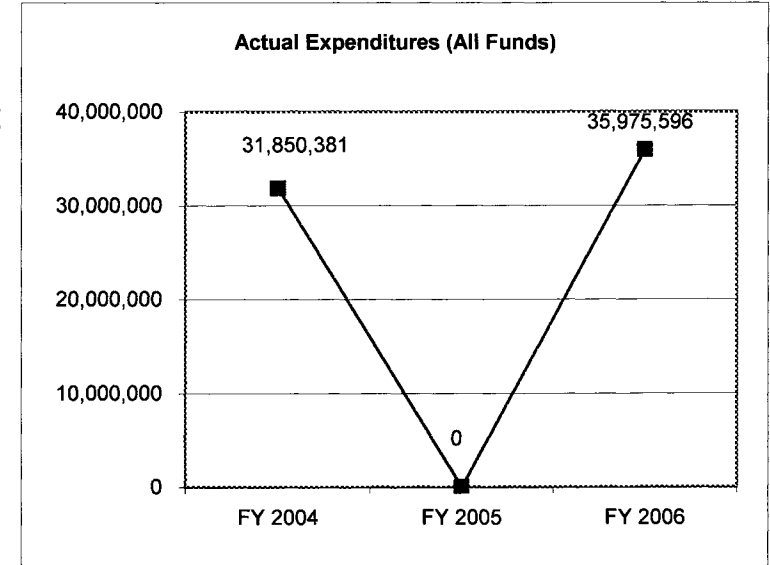
A goal of the Missouri Medicaid program is for each child to be healthy. The purpose of the services provided by the school is to ensure a comprehensive, preventative health care program for Medicaid eligible children. The program provides early and periodic (EPSDT) medical/dental screenings, diagnosis and treatment to correct or improve defects and chronic conditions found during the screenings.

3. PROGRAM LISTING (list programs included in this core funding)

DESE Services

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	33,230,000	0	35,975,608	33,369,908 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	33,230,000	0	35,975,608	N/A
Actual Expenditures (All Funds)	31,850,381	0	35,975,596	N/A
Unexpended (All Funds)	1,379,619	0	12	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	1,379,619	0	12	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" appropriations for Federal Fund for FY 2004, FY 2006 and FY 2007.

(1) Funding for DESE services transferred to one section - DESE Services.

(2) Funding appropriated in the Department of Elementary and Secondary Education's budget.

(3) Expenditures of \$30,960 were paid from the Supplemental pool in FY06.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES
DESE SERVICES

5. CORE RECONCILIATION DETAIL

				Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES										
				PD	0.00	69,954	33,299,954	0	33,369,908	
				Total	0.00	69,954	33,299,954	0	33,369,908	
DEPARTMENT CORE ADJUSTMENTS										
Core Reallocation	1319	6226	EE		0.00	0	2,125,000	0	2,125,000	
Core Reallocation	1319	6226	PD		0.00	0	(2,125,000)	0	(2,125,000)	
NET DEPARTMENT CHANGES					0.00	0	0	0	0	
DEPARTMENT CORE REQUEST										
			EE		0.00	0	2,125,000	0	2,125,000	
			PD		0.00	69,954	31,174,954	0	31,244,908	
			Total		0.00	69,954	33,299,954	0	33,369,908	
GOVERNOR'S RECOMMENDED CORE										
			EE		0.00	0	2,125,000	0	2,125,000	
			PD		0.00	69,954	31,174,954	0	31,244,908	
			Total		0.00	69,954	33,299,954	0	33,369,908	

FY08 Department of Social Services Report #10

DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
DESE SERVICES								
CORE								
PROFESSIONAL SERVICES	2,125,870	0.00	0	0.00	2,125,000	0.00	2,125,000	0.00
TOTAL - EE	2,125,870	0.00	0	0.00	2,125,000	0.00	2,125,000	0.00
PROGRAM DISTRIBUTIONS	33,849,726	0.00	33,369,908	0.00	31,244,908	0.00	31,244,908	0.00
TOTAL - PD	33,849,726	0.00	33,369,908	0.00	31,244,908	0.00	31,244,908	0.00
GRAND TOTAL	\$35,975,596	0.00	\$33,369,908	0.00	\$33,369,908	0.00	\$33,369,908	0.00
GENERAL REVENUE	\$69,954	0.00	\$69,954	0.00	\$69,954	0.00	\$69,954	0.00
FEDERAL FUNDS	\$35,905,642	0.00	\$33,299,954	0.00	\$33,299,954	0.00	\$33,299,954	0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Department of Elementary and Secondary Education (DESE)

Program is found in the following core budget(s): Department of Elementary and Secondary Education (DESE)

1. What does this program do?

PROGRAM SYNOPSIS: Provides funding for payments for school-based administrative services and school-based EPSDT services.

The Department of Elementary and Secondary Education (DESE) core appropriation provides funding for payment for school-based administrative services and school-based EPSDT services consisting of medical/dental screenings, diagnosis and treatment to correct or improve defects and chronic conditions. An interagency agreement is in place between the Division of Medical Services and the DESE so that cooperative efforts would be used to provide the most efficient administration of the EPSDT program. The provision of EPSDT administration by DESE has been determined to be an effective method of coordinating services and improving care associated with providing identified services which are beyond the scope of the state plan but which are medically necessary and Medicaid covered services. The federal share of expenditures for these services provided by DESE are being paid through this appropriation.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

The authority for this appropriation is the authority associated with the services reflected above.

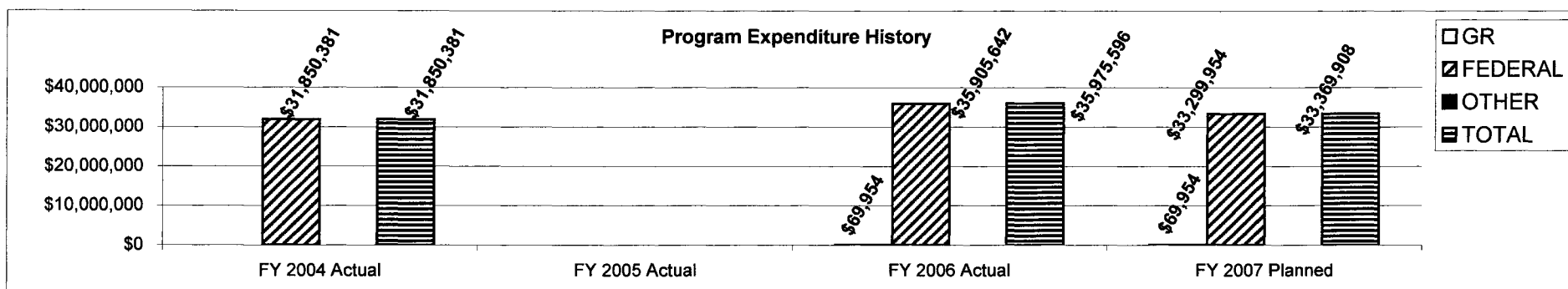
3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding. States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY 08 is a blended 62.22% federal match. The state matching requirement is 37.78%.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



*FY2005 appropriation transferred to the Department of Elementary and Secondary Education

6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

Participating School Districts		
SFY	Actual	Projected
2004	319	
2005	358	
2006	375	380
2007		393
2008		411
2009		431

Eligibles:
Any school district in the state.

7d. Provide a customer satisfaction measure, if available.

FY08 Department of Social Services Report #9

DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
STATE MEDICAL								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	181,450	0.00	2	0.00	2	0.00	2	0.00
TOTAL - EE	181,450	0.00	2	0.00	2	0.00	2	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	25,147,168	0.00	25,486,491	0.00	25,486,491	0.00	25,486,491	0.00
PHARMACY REIMBURSEMENT ALLOWAN	846,090	0.00	535,223	0.00	535,223	0.00	535,223	0.00
HEALTH INITIATIVES	342,834	0.00	353,437	0.00	353,437	0.00	353,437	0.00
TOTAL - PD	26,336,092	0.00	26,375,151	0.00	26,375,151	0.00	26,375,151	0.00
TOTAL	26,517,542	0.00	26,375,153	0.00	26,375,153	0.00	26,375,153	0.00
Pharmacy PMPM Increase - 1886034								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	1,163,827	0.00	873,415	0.00
TOTAL - PD	0	0.00	0	0.00	1,163,827	0.00	873,415	0.00
TOTAL	0	0.00	0	0.00	1,163,827	0.00	873,415	0.00
Physician-Related Rate Incr - 1886058								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	418,313	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	418,313	0.00
TOTAL	0	0.00	0	0.00	0	0.00	418,313	0.00
Health Risk Appraisals - 1886060								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	0	0.00	158,231	0.00
TOTAL - PD	0	0.00	0	0.00	0	0.00	158,231	0.00
TOTAL	0	0.00	0	0.00	0	0.00	158,231	0.00
GRAND TOTAL	\$26,517,542	0.00	\$26,375,153	0.00	\$27,538,980	0.00	\$27,825,112	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: State Medical

Budget Unit: 90585C

1. CORE FINANCIAL SUMMARY

	FY 2008 Budget Request			
	GR	Federal	Other	Total
PS				
EE	2			2
PSD	25,486,491		888,660	26,375,151
TRF				
Total	25,486,493		888,660	26,375,153

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Health Initiative Fund (HIF) (0275)
Pharmacy Reimbursement Allowance Fund (0144)

	FY 2008 Governor's Recommendation			
	GR	Fed	Other	Total
PS				
EE	2			2
PSD	25,486,491		888,660	26,375,151
TRF				
Total	25,486,493		888,660	26,375,153

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Health Initiative Fund (HIF) (0275)
Pharmacy Reimbursement Allowance Fund (0144)

2. CORE DESCRIPTION

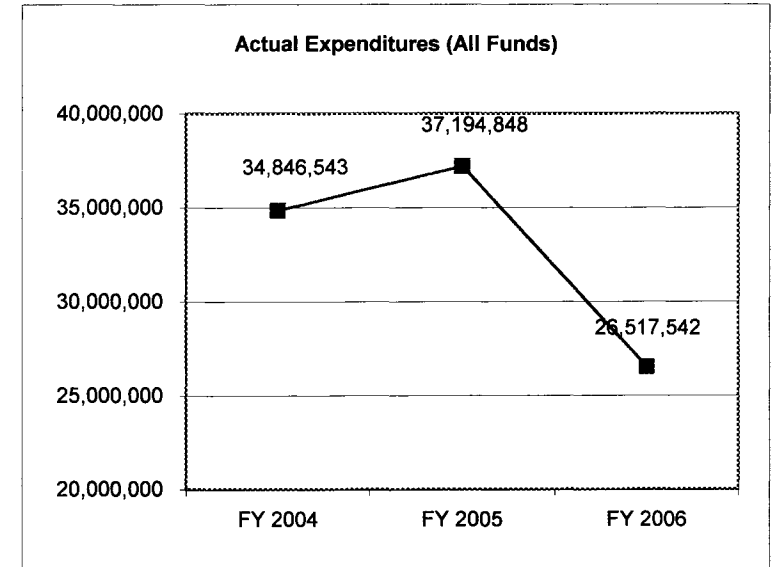
This core request is for the continued funding of the fee-for-service programs for the State Medical eligibles. Funding is necessary to provide health care services to this population.

3. PROGRAM LISTING (list programs included in this core funding)

State Medical Services

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	36,744,182	38,339,695	26,528,145	26,375,153
Less Reverted (All Funds)	(10,603)	(10,603)	(10,603)	N/A
Budget Authority (All Funds)	36,733,579	38,329,092	26,517,542	N/A
Actual Expenditures (All Funds)	34,846,543	37,194,848	26,517,542	N/A
Unexpended (All Funds)	1,887,036	1,134,244	0	N/A
Unexpended, by Fund:				
General Revenue	698,112	0	0	N/A
Federal	0	0	0	N/A
Other	1,188,924	1,134,244	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

(1) Lapse of \$846,090 is excess Pharmacy Reimbursement Allowance Funds. There was no cash to support PFRA authority. Lapse of \$ 342,834 is excess Health Initiative Funds.

(2) Lapse of \$846,090 is excess Pharmacy Reimbursement Allowance Funds. Lapse of \$288,154 is excess Health Initiative Funds.

(3) Expenditures of \$1,438,464 were paid from the Supplemental Pool in FY 2006. SB 539 eliminated the General Relief program.

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**STATE MEDICAL**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	EE	0.00	2	0	0	2	
	PD	0.00	25,486,491	0	888,660	26,375,151	
	Total	0.00	25,486,493	0	888,660	26,375,153	
DEPARTMENT CORE REQUEST							
	EE	0.00	2	0	0	2	
	PD	0.00	25,486,491	0	888,660	26,375,151	
	Total	0.00	25,486,493	0	888,660	26,375,153	
GOVERNOR'S RECOMMENDED CORE							
	EE	0.00	2	0	0	2	
	PD	0.00	25,486,491	0	888,660	26,375,151	
	Total	0.00	25,486,493	0	888,660	26,375,153	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
STATE MEDICAL								
CORE								
PROFESSIONAL SERVICES	181,450	0.00	2	0.00	2	0.00	2	0.00
TOTAL - EE	181,450	0.00	2	0.00	2	0.00	2	0.00
PROGRAM DISTRIBUTIONS	26,336,092	0.00	26,375,151	0.00	26,375,151	0.00	26,375,151	0.00
TOTAL - PD	26,336,092	0.00	26,375,151	0.00	26,375,151	0.00	26,375,151	0.00
GRAND TOTAL	\$26,517,542	0.00	\$26,375,153	0.00	\$26,375,153	0.00	\$26,375,153	0.00
GENERAL REVENUE	\$25,328,618	0.00	\$25,486,493	0.00	\$25,486,493	0.00	\$25,486,493	0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00	\$0	0.00
OTHER FUNDS	\$1,188,924	0.00	\$888,660	0.00	\$888,660	0.00	\$888,660	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: State Medical

Program is found in the following core budget(s): State Medical

1. What does this program do?

PROGRAM SYNOPSIS: Provides payment for services for State Medical eligibles. State Medical eligibles are individuals who do not meet categorical criteria for Title XIX.

The State Medical program, funded solely by state funds, provides health care services for individuals who do not meet categorical eligibility criteria for Title XIX. State Medical recipients are in one of four categories of eligibility: Child Welfare Services (CWS); Blind Pension (BP); Presumptive Eligibility for Pregnant Women; or medical care for youth in the custody of the Division of Youth Services (DYS-GR). The unique aspect of the State Medical appropriation is that payments are made for certain eligibility groups only, but for nearly all the same services which are reimbursed for Title XIX eligibles.

All Medical Assistance programs which are available through the Title XIX program are also available through the State Medical program with the exception of the following: Buy-In, HIPP, transplant and NEMT.

Child Welfare Services (CWS) - These eligibles are children who are in the legal care and custody of the Children's Division and have been placed in foster care, but are not eligible for MAF - Foster Care Medicaid payments (not eligible for federal Title IV-E through the Children's Division). These children are identified as Homeless, Dependent, and Neglected (HDN), but due to income standards are not eligible for federal Title XIX medical assistance.

Blind Pension (BP) - The Blind Pension program was established in 1921 and is financed entirely by state funds. This program provides assistance for blind persons who do not qualify under the supplemental aid to the blind law and who are not eligible for Supplemental Security Income (SSI) benefits. Each eligible person receives a monthly cash grant (Family Support Division appropriation) and State Medical assistance. In order to qualify for the BP program, a person must meet all of the following eligibility requirements: 18 years of age or older; living in the state; has not given away, sold or transferred real or personal property worth more than \$20,000; is of good moral character; has no sighted spouse living in Missouri who can provide support; does not publicly solicit alms; is determined blind as defined by RSMo. 290.040; is found to be ineligible for Supplemental Aid to the Blind; is willing to have medical treatment or an operation to cure blindness (unless he/she is 75 years of age or older); is not a resident of a public, private, or endowed institution except a public medical institution; and is found ineligible to receive federal Supplemental Security Income (SSI) benefits.

Presumptive Eligibility for Pregnant Women - This is a temporary eligibility program that covers services provided to pregnant women while they wait for formal determination of Medicaid eligibility. The recipient is State Medical eligible from the time of eligibility rejection to the end of the temporary eligibility period. These recipients may receive ambulatory prenatal care to include the following services: physician/clinic, nurse midwife, diagnostic lab and x-ray, pharmacy, and outpatient hospital services.

Division of Youth Services - General Revenue (DYS-GR) - This program covers youth in the legal custody of the Division of Youth Services (DYS) who reside in facilities of 25 beds or more (and thus cannot qualify for Medicaid coverage since they reside in an institutional setting). Every youth that is committed to DHS is originally set up in this category for medical coverage. When the residential setting is determined, if the commitment is to a facility of 25 beds or more, then the child remains eligible for DHS-GR. Otherwise, eligibility is established for Title XIX Medicaid for those children committed to facilities with less than 25 beds. Children placed in a not-for-profit residential group facility (RGF) by a juvenile court are Medicaid eligible during their term of placement. Children who are placed in such homes by their parent(s), and who are already eligible for Medicaid coverage, will continue to receive Medicaid benefits while in the group.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.151, 208.152, 191.831

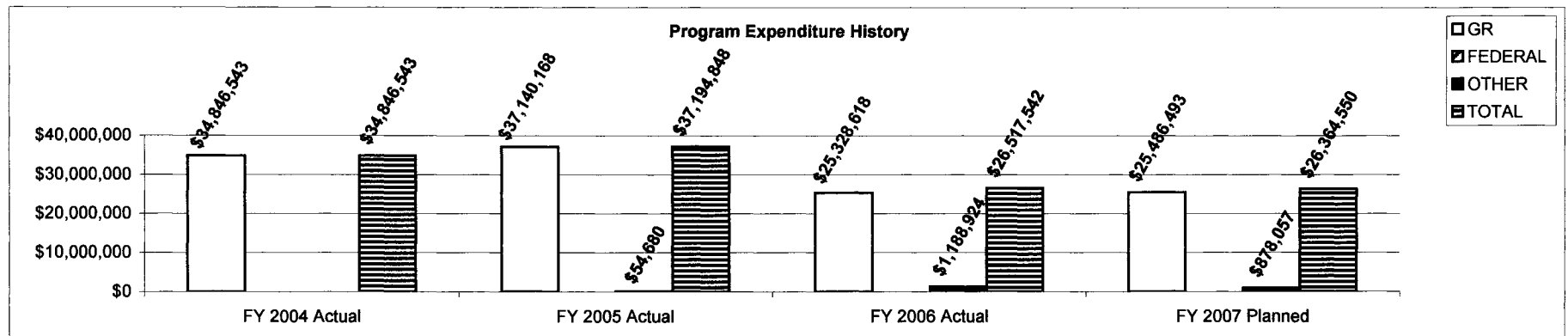
3. Are there federal matching requirements? If yes, please explain.

No.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

Health Initiatives Fund (0275) and Pharmacy Federal Reimbursement Allowance Fund (0144).

7a. Provide an effectiveness measure.

This appropriation represents a group of eligibles and not one program. Effectiveness measures affecting the State Medical appropriation are incorporated into fee-for-service program sections.

7b. Provide an efficiency measure.

This appropriation represents a group of eligibles and not one program. Efficiency measures affecting the State Medical appropriation are incorporated into fee-for-service program sections.

7c. Provide the number of clients/individuals served, if applicable.

Eligibles:

Eligibles include Child Welfare Services, Blind Pension, Presumptive Eligibility for Pregnant Women, Division of Youth Services General Revenue

State Medical Recipients by Category								
SFY	Child Welfare Services		Blind Pension		Presumptive Eligibility For Pregnant Women		DYS - GR	
	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected
2004	615	583	2,835	2,791	1,330	0	564	576
2005	677	630	2,857	2,839	1,477	0	504	576
2006	610	745	2,898	3,143	1,758	1,580	383	510
2007		610		2,940		1,952		383
2008		610		2,982		2,168		383
2009		610		3,025		2,408		383

7d. Provide a customer satisfaction measure, if available.

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DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAID SUPP POOL								
CORE								
EXPENSE & EQUIPMENT								
TITLE XIX-FEDERAL AND OTHER	1,840,586	0.00	150,000	0.00	150,000	0.00	150,000	0.00
PHARMACY REBATES	206,005	0.00	0	0.00	0	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	947,636	0.00	150,000	0.00	150,000	0.00	150,000	0.00
TOTAL - EE	2,994,227	0.00	300,000	0.00	300,000	0.00	300,000	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	3,151,147	0.00	0	0.00	0	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	81,682,554	0.00	23,957,486	0.00	23,957,486	0.00	23,957,486	0.00
UNCOMPENSATED CARE FUND	13,188,560	0.00	1	0.00	1	0.00	1	0.00
PHARMACY REBATES	32,969,188	0.00	1	0.00	1	0.00	1	0.00
THIRD PARTY LIABILITY COLLECT	6,623,518	0.00	7,421,156	0.00	7,421,156	0.00	7,421,156	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	0	0.00	1	0.00	1	0.00	1	0.00
NURSING FACILITY FED REIM ALLW	181,500	0.00	181,500	0.00	181,500	0.00	181,500	0.00
PREMIUM	7,637,940	0.00	3,837,940	0.00	3,837,940	0.00	3,837,940	0.00
TOTAL - PD	145,434,407	0.00	35,398,085	0.00	35,398,085	0.00	35,398,085	0.00
TOTAL	148,428,634	0.00	35,698,085	0.00	35,698,085	0.00	35,698,085	0.00
GRAND TOTAL	\$148,428,634	0.00	\$35,698,085	0.00	\$35,698,085	0.00	\$35,698,085	0.00

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CORE DECISION ITEM

Department: Social Services
Division: Medical Services
Appropriation: Medicaid Supplemental Pool

Budget Unit: 90582C

FY 2008 Budget Request					FY 2008 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Fed	Other	Total
PS					PS				
EE		150,000	150,000	300,000	EE		150,000	150,000	300,000
PSD		23,957,486	11,440,599	35,398,085	PSD		23,957,486	11,440,599	35,398,085
TRF					TRF				
Total		24,107,486	11,590,599	35,698,085	Total		24,107,486	11,590,599	35,698,085
FTE				0.00	FTE				0.00

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Est. Fringe	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Premium Fund (0885)
Third Party Liability Collections (TPL) (0120)
Uncompensated Care Fund (UCF) (0108)
Pharmacy Rebate Fund (0114)
Federal Reimbursement Allowance (FRA) Fund (0142)
Nursing Facility Federal Reimbursement Allowance (NFRA) (0196)

Notes: An "E" is requested for Federal Fund, Uncompensated Care Fund, Pharmacy Rebates Fund and the Federal Reimbursement Allowance Fund.

Other Funds: Premium Fund (0885)
Third Party Liability Collections (TPL) (0120)
Uncompensated Care Fund (UCF) (0108)
Pharmacy Rebate Fund (0114)
Federal Reimbursement Allowance (FRA) Fund (0142)
Nursing Facility Federal Reimbursement Allowance (NFRA) (0196)

Notes: An "E" is requested for Federal Fund, Uncompensated Care Fund, Pharmacy Rebates Fund and the Federal Reimbursement Allowance Fund.

2. CORE DESCRIPTION

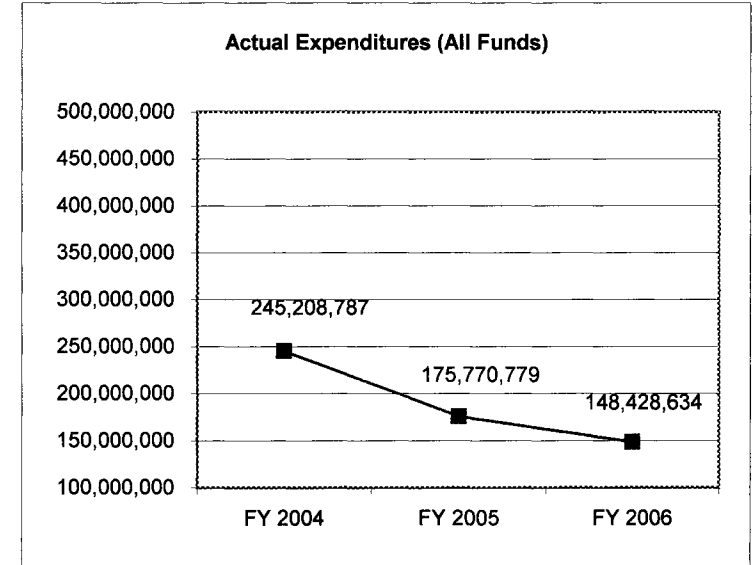
This core request is for the continued funding of the Medicaid Supplemental Pool. The Supplemental Pool is needed to enable the division to respond to unanticipated changes in the cost of providing health care to Medicaid recipients.

3. PROGRAM LISTING (list programs included in this core funding)

Supports Medicaid Program

4. FINANCIAL HISTORY

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Current Yr.
Appropriation (All Funds)	255,351,411	300,979,620	148,640,304	35,698,085 E
Less Reverted (All Funds)				N/A
Budget Authority (All Funds)	255,351,411	300,979,620	148,640,304	N/A
Actual Expenditures (All Funds)	245,208,787	175,770,779	148,428,634	N/A
Unexpended (All Funds)	10,142,624	125,208,841	211,670	N/A
Unexpended, by Fund:				
General Revenue	0	5,430,992	0	N/A
Federal	7,460,141	77,332,395	211,670	N/A
Other	2,682,483	42,445,454	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

NOTES:

Estimated "E" for UCF, Pharmacy Rebates Fund, FRA and Federal Fund. "E" is for FY 2005 through FY 2007.

(1) Lapse of \$5,587,602 is excess federal authority. Lapse of \$1,381,645 is excess Third Party Liability authority.

(2) FY05 unexpended includes \$85 million (\$33 million in IGT and \$52 million Federal funds) disproportionate share hospital maximization. The cash was earned in another manner.

(3) Lapsed authority appropriated for Medicaid program expenditures was \$5.4 million GR; \$6.1 million Third Party Liability and \$21.3 million Federal funds.

4. FINANCIAL HISTORY

Supplemental Pool Payments By Services

	FY 2004	FY 2005	FY 2006
Pharmacy	\$55,667,493	\$5,079,767	\$408
Physician	\$60,051,457	\$66,614,598	\$27,623,367
Dental	\$22,786,492	\$5,246,342	\$13,229,886
Premium Payments	\$3,708,058	\$6,926,710	\$0
Home & Community Based Services	\$40,116	\$0	\$0
Nursing Facilities	\$380,000	\$10,488,972	\$30,673,390
Telephone Reassurance	\$0	\$2,097	\$1,372
Rehab & Specialty Services	\$22,442,764	\$21,784,471	\$22,835,407
Non-Emergency Medical Transportation	\$13,677,899	\$0	\$5,560,656
Managed Care	\$8,675,665	\$4,447,408	\$0
Hospital Care	\$10,737,113	\$24,843,767	\$46,150,882
1115 Waiver - Adults	\$369,721	\$0	\$0
1115 Waiver - Children	\$16,345,048	\$3,399,176	\$0
DESE Services	\$0	\$25,852	\$30,960
State Medical	\$0	\$0	\$1,438,464
Pharmacy Enhancement Admin	\$0	\$0	\$881,963
Total	\$214,881,826	\$148,859,160	\$148,426,755

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES**MEDICAID SUPP POOL**

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	EE	0.00	0	150,000	150,000	300,000	
	PD	0.00	0	23,957,486	11,440,599	35,398,085	
	Total	0.00	0	24,107,486	11,590,599	35,698,085	
DEPARTMENT CORE REQUEST							
	EE	0.00	0	150,000	150,000	300,000	
	PD	0.00	0	23,957,486	11,440,599	35,398,085	
	Total	0.00	0	24,107,486	11,590,599	35,698,085	
GOVERNOR'S RECOMMENDED CORE							
	EE	0.00	0	150,000	150,000	300,000	
	PD	0.00	0	23,957,486	11,440,599	35,398,085	
	Total	0.00	0	24,107,486	11,590,599	35,698,085	

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DECISION ITEM DETAIL

Budget Unit	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008	FY 2008	FY 2008
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	GOV REC	GOV REC
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE
MEDICAID SUPP POOL								
CORE								
PROFESSIONAL SERVICES	2,994,227	0.00	300,000	0.00	300,000	0.00	300,000	0.00
TOTAL - EE	2,994,227	0.00	300,000	0.00	300,000	0.00	300,000	0.00
PROGRAM DISTRIBUTIONS	145,434,407	0.00	35,398,085	0.00	35,398,085	0.00	35,398,085	0.00
TOTAL - PD	145,434,407	0.00	35,398,085	0.00	35,398,085	0.00	35,398,085	0.00
GRAND TOTAL	\$148,428,634	0.00	\$35,698,085	0.00	\$35,698,085	0.00	\$35,698,085	0.00
GENERAL REVENUE	\$3,151,147	0.00	\$0	0.00	\$0	0.00	\$0	0.00
FEDERAL FUNDS	\$83,523,140	0.00	\$24,107,486	0.00	\$24,107,486	0.00	\$24,107,486	0.00
OTHER FUNDS	\$61,754,347	0.00	\$11,590,599	0.00	\$11,590,599	0.00	\$11,590,599	0.00

PROGRAM DESCRIPTION

Department: Social Services

Program Name: Medicaid Supplemental Pool

Program is found in the following core budget(s): Medical Supplemental Pool

1. What does this program do?

PROGRAM SYNOPSIS: Provides funding for the division to respond to unanticipated changes in the cost of providing health care to Medicaid recipients.

The Medicaid Supplemental Pool Section was the result of rapidly expanding Medicaid eligibles and unpredictability of resulting costs. Substantial supplemental budget requests in successive years prompted the Missouri state legislature to appropriate funding for unanticipated Medicaid expenditures. Typically, the supplemental pool has been utilized by the legislature to appropriate funding under certain unique circumstances. These include funding for major one-time program expenditures, such as residual claims, and funding to be made available for unanticipated fee-for-service and/or managed care expenditures.

2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

The legal authority for the Supplemental Pool is the authority associated with each Medicaid program. See each program description for the specific federal and state authority.

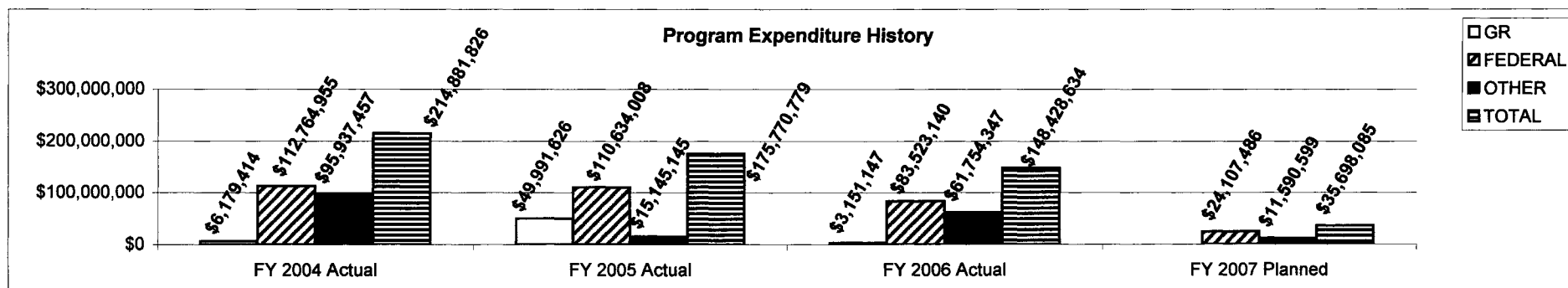
3. Are there federal matching requirements? If yes, please explain.

The federal matching requirements for the Medicaid Supplemental Pool are the requirements associated with any of the Medicaid programs paid from the supplemental pool. See each program description for specific federal matching requirements.

4. Is this a federally mandated program? If yes, please explain.

The Medicaid Supplemental Pool supports both mandated and non-mandated programs. See each program description for specifics.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other" funds?

Third Party Liability Collections Fund (0120), Premium Fund (0885), Nursing Facility Federal Reimbursement Allowance Fund (0196), Uncompensated Care Fund (0108), Pharmacy Rebates Fund (0114), Federal Reimbursement Allowance Fund (0142) and Intergovernmental Transfer Fund (0139) not available in FY06 and FY07.

7a. Provide an effectiveness measure.

This appropriation represents a group of eligibles and not one program. Effectiveness measures affecting the Medicaid Supplemental Pool appropriation are incorporated into fee-for-service program sections.

7b. Provide an efficiency measure.

This appropriation represents a group of eligibles and not one program. Efficiency measures affecting the Medicaid Supplemental Pool appropriation are incorporated into fee-for-service program sections.

7c. Provide the number of clients/individuals served, if applicable.

Supplemental Pool Expenditures		
SFY	Actual	Projected
2003	\$267.2 mil	
2004	\$214.9 mil	
2005	\$175.8 mil	\$35.7 mil
2006	\$148.4 mil	\$35.7 mil
2007		\$35.7 mil
2008		\$35.7 mil

(Excludes UPL maximization transactions)

7d. Provide a customer satisfaction measure, if available.